SOCIAL SUPPORT AND HELP-SEEKING IN PARASUICIDE VERSUS DEPRESSION IN YOUNG ADULTS

and RESEARCH PORTFOLIO

PART ONE

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1. MAJOR RESEARCH PROJECT LITERATURE REVIEW

Social Support, Help-Seeking and Shame in Suicide:

A literature review and new directions for research.

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Abstract

Purpose The aim of this paper is to review some of the psychological factors related to suicidal behaviour within a young adult population. A number of individual and demographic variables have been identified as risk factors for suicide but it is not clear in what way they relate to increased risk of suicidal behaviour. This paper reviews studies examining how certain psychological factors may be related to suicide.

Method Papers were identified relating to three variables: (1) Social Support, (2) Help-Seeking Behaviour, and (3) Feelings of shame and guilt, in relation to suicidal behaviour. Studies were identified that considered how these factors may relate to increased risk of suicidality and their implications for suicide prevention. This was considered primarily in relation to a young adult population.

Results The studies reviewed indicate that suicide is a significant problem and represents a preventable cause of death. However the factors influencing suicide are complex and are likely to require multi-faceted interventions. Parasuicide participants may perceive their social support as less satisfactory than controls and this may affect their ability to seek help at a time of crisis. Feelings of shame appear particularly relevant to psychopathology and increased risk of suicidality, and may in themselves constitute a barrier to help-seeking behaviour.

Introduction

A reduction in the rate of suicide within the general population, and within the population of people with serious mental illness, has been identified as a priority area for health strategy (Health of the Nation, Department of Health, 1992; Our Healthier Nation, Secretary of State for Health, 1998). Completed suicides represent a significant cause of premature death. In addition to representing a preventable cause of death, suicide is also an emotive and distressing event for friends, family and carers of the deceased. However, interventions to reduce the suicide rate are difficult because of the complex factors relating to suicide risk and suicide trends in general.

Rates of Suicide

An area of concern has been the marked increase in suicide attempts and completed suicides in young people over the last 20 years. In many developed countries, suicide is one of the leading causes of death among young people (World Health Organisation). However, the trends in suicide rates are far from simple. An article by Charlton et al (1992) examining suicide trends in England and Wales illustrates the complexities of recent trends in suicide rates.

Male vs. female suicide rates

Deaths due to suicide reached a peak for both sexes in 1963. Since then women's suicide rates have consistently fallen. Men's suicide rates fell until the early 1970's, since when they have been consistently rising. This is the first time since 1911 that suicide rates for males and females have moved in opposite directions. The reported suicide rates in the UK for the period 1986-1988 for the age group 25-44 were: males

16 per 100,000 population and females 5 per 100,000 population. Within the UK Scotland and Northern Ireland were reported to have higher suicide rates than England and Wales (Charlton et al, 1992).

Suicide rates according to age.

Charlton et al (1992) also demonstrated that there are differences in suicide rates for different age groups for both men and women. Since the early 1970's the rates for men aged 45 and over have fallen while the rates for men aged 45 and under have risen so that they exceed the rates for the older group. The exception to this were men aged 75 and over who still had the highest rates of suicide, and those aged 15-24 who had rates substantially lower than those of the older age-groups. However, while the rate for males aged 15-24 was lower than for the older age-groups, it is worth noting that, in the UK, the suicide rate for male adolescents has nearly doubled since 1975 (Williams, 1997a). For women the suicide rates for all groups, except those aged under 25 have fallen since 1965. There is evidence of a convergence of suicide rates for different age groups, although the rates are still higher among the age groups 45 and over.

Overall then, the rate of suicide for women has generally fallen since 1963. The rate for men over 45 has fallen (with the exception of men aged 75 and over) while the suicide rate has risen for men aged 45 and under. This increase has been particularly marked among males aged 15-24 since 1982 (Williams, 1997b).

Rates for Parasuicide

These figures for completed suicides contrast with the rates for parasuicide (suicidal behaviour with a non-fatal consequence). For an extended period of time the parasuicide rate was much higher for women than for men. In 1976, in the UK, the female: male parasuicide ratio was 2.1:1, and in 1984 the ratio was 1.9:1. This pattern has shifted again in recent years, so that in 1994 the female: male ratio was 1.4:1 (Williams, 1997b). In contrast to completed suicide, parasuicide occurs predominantly among the younger age groups. In a study by Hawton et al (unpublished) quoted in Williams (1997b) 71% of those engaging in parasuicide were under 35, with the most vulnerable age for women being 15-19, and for men 20-24. While the female: male ratio for parasuicide appears to be evening out, it seems that this is not due to a reduction in the number of women engaging in parasuicidal behaviours but is rather due to a rise in the number of males engaging in parasuicide (Williams, 1997b). Hawton et al (unpublished) report parasuicide rates within the UK of 264 per 100,000 for men and 368 per 100,000 for women.

While the proportion of males and females engaging in parasuicide is now relatively equal, for a long time there was a situation where young women were much more likely to engage in parasuicidal behaviours yet the rate of completed suicides for this group was consistently low. For young men however, there was a consistent increase in the rate of completed suicides and this now appears to be being matched by increasing engagement in parasuicidal behaviours as well.

Given the variation in trends in completed suicides according to time, gender and age, and the differing trends in rates for suicide compared to parasuicide, it is clear that the

factors influencing suicide are likely to be complex. This has profound implications for the understanding and prevention of suicide.

Factors related to suicide

A large number of factors have been identified as risk factors for either suicide, or parasuicide, or both. Williams, (1997a) provides a useful review of the factors identified:

(i) Individual variables – e.g. male gender (Woodroofe et al, 1993), increasing age (Mattunen et al, 1992)

(ii) Suicidal behaviour – e.g. verbalised ideation or previous suicide attempts (Mattunen et al, 1992; Brent et al, 1993a)

(iii) Mental Health Issues – psychiatric disorders, alcohol or substance abuse/dependence, other diagnoses (Mattunen et al 1992; Brent et al, 1993b)

(iv) Life events – e.g. acute life crisis (Shaffer, Garland, Gould, Fisher & Trautman, 1988), legal or disciplinary crisis/difficulties (Shaffer, 1974; Brent et al, 1993b)

(v) Access to means – availability of firearms in the home (Brent et al, 1991, 1993b)

While there are clearly a large number of factors which can be shown to be associated with an increased risk of suicidality, it is not necessarily clear in what way these factors are relevant or may influence suicide rates. This is illustrated by an article by Kelleher (1998) examining youth suicide trends in the Republic of Ireland. The Republic of Ireland has seen a significant increase in its suicide rate over the last 20

years, particularly within males under 24. During the same period there have been a number of social changes, which may or may not prove relevant to the increasing suicide rate. For instance, there has been a marked decrease in the public practicē of religion, which may have implications for social support and a decrease in the social prohibitions preventing suicide. However, this decrease has been most marked in urban areas, while the greatest rise in young people's suicide has been in rural areas. Similarly, there has been an increase in the availability of illegal drugs, and drug related factors have been linked with suicide in late adolescence (Hawton et al, 1993). However, the most cases of drug misuse have occurred within the area with the lowest suicide rate (Kelleher et al, 1998). Thirdly, there has been a significant increase in the proportion of young people continuing to tertiary level education. However there does not appear to be evidence of an association between the incidence of suicide and stressors such as the time of sitting, or the release of results, of examinations. Kelleher (1998) also suggests that students actually have the lowest rate of suicide. Finally, further social change has occurred with the legalisation of divorce and a fall in marriage rates. However, as Kelleher points out, if changes in family structure are related to the increase in suicide rates it will be important to identify why this appears to impact more profoundly on young males compared to young females.

This paper by Kelleher illustrates the difficulties, not just in identifying factors related to suicide risk, but also in identifying how these may work to affect suicidality, as this has implications for the development of appropriate suicide prevention strategies. As Mosicki (1997) identifies "Suicide is a complex, long-term outcome that requires

complex theoretical models for appropriate study and complex interventions for effective prevention " (p.512). In addition, Williams (1997a) has pointed out that

> "The wide spectrum of problems which are related to, and potentially cause, suicide creates a further problem for putting research findings into practice. . . . Even if the risk factors determined . . . correctly describe "high risk" groups or cause suicidal behaviour, it does not easily follow that they will be useful for either clinical work or preventative strategies" (p. 178)

The prevention of suicide

While there may be difficulties in the understanding of suicidal behaviour and its causes, given the seriousness of the consequences of a suicidal act, it is important to continue to develop an understanding of suicide and to generate strategies for its prevention.

Williams (1997a) has outlined three levels of suicide prevention:

Primary prevention refers to the reduction of risk factors known to predispose to suicide. This might include modification of social factors such as unemployment or deprivation.

Secondary prevention requires the identification of "high risk" individuals. This might include identification of individuals experiencing depression and some degree of suicidal ideation and provision of supportive services prior to a crisis. Identification might be by health professionals or by those close to the person. Alternatively, the person may self-identify and seek help. Secondary prevention

would include the provision of crisis lines, and identification of high-risk individuals through clinical contact and provision of appropriate services.

Tertiary prevention relates to the provision of effective services for those actively at risk of death from suicide. This may involve restricted access to means of suicide and medical and mental health care provision.

In relation to the primary prevention of suicide, much of the work required relates to social factors and falls outwith the remit of the health service. In practice then, much prevention work will be at the level of secondary prevention. In considering suicidal behaviour in adolescents, Rey Gex et al (1998) have suggested that "The primary prevention of suicide is both difficult and disappointing, so the identification and treatment of teenagers who are likely to commit suicide . . . remains one of the most effective prevention strategies in this age group" (P.28).

Shame and Suicidality

It has been suggested that one factor which may be related to increased risk of suicidality is feelings of shame. There is a developing literature which suggests that feelings of shame and guilt are associated with feelings of depression and increased psychopathology (Tangney, 1991; Tangney et al, 1992; Gilbert et al, 1994; Lester, 1997). "Shame" and "guilt" appear to be related and the terms are sometimes used interchangeably. However, important distinctions have been made between the two states and it has been suggested that shame may be particularly relevant to the study of suicide.

In differentiating between shame and guilt the focus of the negative affect has been suggested as the most important distinction.

> "Whereas in guilt the focus of the self is on the behavior, the inadequacy to meēt a certain standard, in shame the object is the whole self, and we conclude that we are no good, inadequate and unworthy" (Lester, 1997, p.352)

Thus feelings of guilt focus on a particular behaviour, while shame encompasses the entire self.

Lewis (1971) suggested that shame prone individuals would develop different psychological symptoms to guilt-prone individuals. Lewis suggested that shame-prone individuals were vulnerable to affective disorders (especially depression) while guilt-prone persons were more vulnerable to thought-related disorders (e.g. paranoia or obsessive-compulsive disorders). However, there has been little, if any, evidence to support this differentiation in psychopathology.

Lester (1997) suggested that the role of shame has been neglected as a motivating factor in suicide, and there is some evidence that significant feelings of shame and guilt may be related to increased psychopathology. Tangney et al (1992) suggested that in guilt, as the focus of concern is some specific action, the remorse and regret engendered can act as a motivation for reparation, and in this way the guilt can be remedied. In shame however, the focus of concern is the entire self "and the entire self is painfully scrutinized and negatively evaluated" (p.469). As a result, the wish is to conceal the reasons for the feelings of shame and this can block resolution of the negative affect. "Shame itself presents an insoluble dilemma because at issue is a malignant self, not a malignant behavior" (p.476). In a sense, as the entire self is

evaluated negatively, removal of the self might appear to represent a means of resolving the problem. Thus, because of their global nature, feelings of shame may be particularly devastating, and may also represent a barrier to seeking support.

Tangney et al (1992) used two scenario-based measures of shame and guilt to investigate the relationships between shame, guilt, and a range of psychological symptoms. They found that proneness to shame was positively correlated with a tendency to make internal, stable and global attributions for negative events, and negatively correlated with internal, stable and, to a lesser extent, global attributions for positive events. Shame-proneness accounted for a substantial portion of variance in depression, above and beyond the variance accounted for by attributional style. Guilt-proneness however, was only moderately related to psychopathology and these moderate correlations were found to result from the shared variance between shame and guilt. These results did not support Lewis' (1971) proposal that shame and guilt were differentially related to unique symptom clusters. However, they did provide some evidence that feelings of shame are related to psychological maladjustment.

Johnson et al (1987) looked at feelings of shame and guilt and their association with adjustment across three different cultures. They found that shame, but not guilt, was associated with scores on a measure of neuroticism. Thus there is some evidence that feelings of shame may be particularly related to psychopathology. Lester (1997) examined the relationship between feelings of shame and guilt and feelings of suicidality and found that propensity for feelings of shame was more strongly correlated with suicidality than was propensity for feelings of guilt.

These studies suggest that shame prone individuals may experience increased psychopathology, and may be at increased risk for suicide. However, it is worth noting that the experiments described have been carried out with non-clinical samples of university undergraduates rather than with a clinical population. It would be important to investigate if a similar pattern of results is shown in a clinical population. If so, this might indicate a group of patients at particular risk of suicide, e.g. patients showing both high depression and shame scores, who would benefit from early psychological intervention.

A study by Alexander et al (1999) looked at feelings of shame and guilt in a depressed population. In contrast to non-clinical studies they found that guilt, but not shame, was associated with feelings of depression. However the authors noted that there may have been a difficulty with the measure used (Shame and Guilt Scale; Gilbert et al, 1991) as there appeared to be a ceiling effect, suggesting the measure might not be detecting high shame scores within the depressed population. The study did find that the levels of shame detected were associated with a stable attributional style for negative outcomes, global negative self-evaluation, submissive behaviour, and internalised anger. This suggests that feelings of shame may still be relevant to psychopathology and suicidal behaviour.

Social support in suicide

Another factor suggested as relevant to suicide risk is social support. Henderson (1981) suggested that a person's perception of a relationship as adequate or inadequate under adversity was associated with the emergence of neurotic symptoms.

Bille-Brahe (1996) investigated the role of social integration and social support in suicide, and found that the kind or amount of reciprocity in social support that a person experiences is related to their risk of suicide. In examining the data from 131 attempted suicides Bille-Brahe found that while the average amount of social support these subjects received was high, it was not equal to the level of need they experienced. It has been suggested that social support is one of the aspects of the social environment that has particular bearing on the course of psychiatric illness (Neeleman & Power, 1994).

Neeleman & Power (1994) examined the role of social support in three groups of psychiatric patients: patients with moderate depression, patients with chronic schizophrenia, and patients who had deliberately self-harmed, and compared them to a group of medical controls. Particularly important was that the study looked at both perceived and ideal social support. All three groups of psychiatric patients reported lower perceived levels of social support than did control subjects. In addition, the depressed and deliberate self-harm patients, but not the psychiatric patients, felt dissatisfied with the available support. The results suggested that perceived deficiencies in social support may be particularly relevant in depressive disorders.

Magne-Ingvar et al (1992) examined the social characteristics and self-rating of social support of 75 inpatients following a suicide attempt. They found that many participants had a less satisfying social network than controls as measured objectively (social characteristics) and described subjectively (self-rating scales). Kralik & Danforth (1992) conducted a study examining coping mechanisms with regard to preventing suicidality in a population of college students. The students self-identified

as having no prior suicidal ideation, mild ideation, severe ideation, or having attempted suicide. The authors concluded that that serious ideators differed from suicide attempters in the relative effectiveness that having social attachments has on preventing suicide behaviour.

Thus, there is some evidence that deficiencies in social support may be particularly relevant in depressive disorders and suicide, and social attachments may be relevant to the prevention of suicidal behaviour.

Help-seeking behaviour and suicide

One way in which social support may be relevant to the prevention of suicide is in help-seeking by an individual prior to engaging in a suicidal act. Tousignant & Hanigan (1993) compared social support following a loss in suicidal or non-suicidal college students. They found that the suicidal group named fewer important persons in their kinship network and had more conflicts with this network than did the nonsuicidal group. The suicidal group was also less ready to inform the network about the loss event, although the number of persons with whom the event was discussed was similar in both groups. Thus, perceptions of social support may affect an individual's ability to seek support and assistance at a time of particular difficulty.

Suicide attempters may also try to seek assistance from health professionals. In theory this should provide an opportunity for the identification of individuals at increased risk of suicide. Hintikka et al (1998) found that 92% of individuals who had displayed suicidal behaviour during the previous 12 months had had some contact with health-

care services at the same time. However, they also found that 90% of non-suicidal individuals had some contact with health-care services. Thus, if a potentially suicidal individual does not highlight their feelings of suicidality they may not be identified during a routine contact.

A study by Michel et al (1997) looked at the contacts of suicide attempters with their GP prior to attempting suicide. While many suicide attempters saw their GP in the month prior to attempting to harm themselves, a substantial number did not discuss suicidal ideation or plans with their GP. In addition, a study by Wolk-Wasserman (1987) suggested doctors did not understand patients' suicidal communications or did not encourage them to discuss them. There may also be a lack of belief on the part of many suicide attempters that a doctor or other health professional could have done anything to help them (Michel et al, 1994). "Thus, there is a discrepancy between the potential role of medical doctors in the prevention of suicidal behaviour and daily practice" (Michel et al, 1997, p.94).

Summary

Suicide is a significant problem and represents a preventable cause of death. There is particular concern at the increasing rate of suicide amongst young men. However, the factors influencing suicide are not clear and it seems likely that suicide is a complex problem that will require carefully constructed models and interventions. In considering the prevention of suicide it will be particularly important to identify groups at increased risk for suicide and arrange early interventions with these groups. A number of factors have been identified as potentially related to a person's risk of

suicidality. These include feelings of shame, social support and willingness/ability to seek assistance prior to a suicidal act. Further investigation of these factors may help in understanding a person's predisposition to, or protection from, suicidality.

References

Alexander, B., Brewin, C.R., Vearnals, S., Wolff, G. & Leff, J. (1999). An investigation of shame and guilt in a depressed sample. British Journal of Medical Psychology, 1999, 72, 323-338

Appleby, L. (1992). Suicide in psychiatric patients: risk and prevention. British Journal of Psychiatry, 1992, 161, 749-758

Bille-Brahe, U. (1996). Measuring social integration and social support. Nordic Journal of Psychiatry, 1996, 50, 41-46

Brent, D.A., Perper, J.A., Moritz, G., Allman, C., Friend, A., Roth, C., Schweers, J., Balach, l., Baugher, M. (1993a) Psychiatric risk factors for adolescent suicide: a case-control study. Journal of the American Academy of Child and Adolescent Psychiatry, 32, 521-529

Brent, D.A., Perper, J.A., Moritz, G., Baugher, M., Allman, C. (1993b). Suicide in adolescents with no apparent psychopathology. Journal of the American Academy of Child and Adolescent Psychiatry, 32, 494-500

Charlton, J., Kelly, S., Dunnell, K., Evans, B., Jenkins, R., & Wallis, R. (1992). Trends in suicide deaths in England and Wales. Population Trends, 1992, 69, 10-16

Gilbert, P., Allan, S., & Pehl, J. (1991). A short measure of shame and guilt. Unpublished manuscript, Mental Health Research Unit, University of Derby.

Gilbert, P., Pehl, J., & Allan, S. (1994). The phenomenology of shame and guilt: An empirical investigation. British Journal of Medical Psychology, 1994, 67, 23-36

Gunnell, D., & Frankel, S. (1994). Prevention of suicide: aspirations and evidence. British Medical Journal, 1994, 308, 1227-1233

Hawton, K., Fagg, J., Simkin, S., Bale, E. & Bond, A. (1994)
Attempted suicide in Oxford. Unpublished report from University Department of Psychiatry, Oxford. In: Williams, M. (1997). Cry of Pain: Understanding suicide and self-harm. Penguin Books, London, 1997

Hawton, K., Fagg, J., Platt, S., et al, (1993). Factors associated with suicide after parasuicide in young people. British Medical Journal, 1993, 306, 1641-1644

Henderson, S. (1981). Social relationships, adversity and neurosis: an analysis of prospective observations. British Journal of Psychiatry, 1981, 138, 391-398

Henderson, S., Byrne, D.G. & Duncan Jones, P. (1981). Neurosis and the social environment. Sydney, Academic Press, 1981

Hintikka, J., Viinamaki, H., Tanskanen, A., Kontula, O. & Koskela, K. (1998). Suicidal ideation and parasuicide in the Finnish general population. Acta Psychiatrica, Scandinavica, 1998, 98, 23-27

Johnson, R.C., Danko, G.P., Huang, Y.H., Park, J.Y., Johnson, S.B., & Nagoshi, C.T., (1987). Guilt, shame and adjustment in three cultures. Personality and Individual Differences, 1987, 8, 357-364.

Kelleher, M.J. (1998). Youth suicide trends in the Republic of Ireland. British Journal of Psychiatry, 1998, 173, 196-197

Kelleher, M.J., Corcoran, P. & Keeley, H.S. et al (1996). Improving procedures for recording suicide statistics. Irish Medical Journal, 1996, 89, 16-17

Kralik, K.M. & Danforth, W.J. (1992). Identification of coping ideation and strategies preventing suicidality in a college-age sample. Suicide & Life-Threatening Behavior, 1992, 22, 167-186

Lester, D. (1997). The role of shame in suicide. Suicide and Life-Threatening Behavior, 1997, Vol. 27, 352-361

Lester, D. (1998). The association of shame and guilt with suicidality. Journal of Social Psychology, 1998, 138, 535-536

Lewis, H.B. (1971). Shame and guilt in neurosis. New York: International Universities Press

Magne-Ingvar, U., Ojehagen, A., & Traskman-Bendz, L. (1992). The social network of people who attempt suicide. Acta Psychiatrica Scandinavica, 1992, 86, 153-158

Mattunen, M.J., Aro, H.M., & Lonnqvist, J.K. (1992). Adolescent suicide: endpoint of long-term difficulties. Journal of the American Academy of Child and Adolescent Psychiatry, 31, 649-654

Michel, K., Runeson, B., Valach, L &., Wasserman, D. (1997). Contacts of suicide attempters with GP's prior to the event: a comparison between Stockholm and Bern. Acta Psychiatrica Scandinavica, 1997, 95, 94-99

Mosicki, E.M., (1997). Identification of suicide risk factors using epidemiologic studies. The Psychiatric Clinics of North America, 1997, 20, 499-517

Neeleman, J. & Power, M.J. (1994). Social support and depression in three groups of psychiatric patients and a group of medical controls. Social Psychiatry & Psychiatric Epidemiology, 1994, 29(1), 46-51

Rey Gex, C., Narring, F., Ferron, C. & Michaud, P.-A. (1998). Suicide attempts among adolescents in Switzerland: prevalence, associated factors and co-morbidity Acta Psychiatrica Scandinavica, 1998, 98, 28-33

Rihmer, Z. (1996). Strategies of suicide prevention: Focus on health care. Journal of Affective Disorders, 1996, 36, 83-91

Seligman, M.E.P., Abramson, L.Y., Semmel, A., & von Baeyer, C. (1979). Depressive Attributional Style. Journal of Abnormal Psychology, 1979, 88, 242-247

Shaffer, D. (1974). Suicide in childhood and early adolescence. Journal of Child Psychology and Psychiatry, 1974, 15, 275-291

Shaffer, D., Garland, A., Gould, M., Fisher, P., & Trautman, P. (1988). Preventing teenage suicide: a critical review. Journal of the American Academy of Child and Adolescent Psychiatry, 1988, 27, 675-687.

Tangney, J.P. (1991). Moral affect: The good, the bad, and the ugly. Journal of Personality and Social Psychology, 1991, 61, 598-607

Tangney, J.P., Wagner, P., and Gramzow, R. (1992). Proneness to shame, proneness to guilt and psychopathology. Journal of Abnormal Psychology, 1992, 101, 469-478.

Tousignant, M. & Hanigan, D. (1993). Crisis support among suicidal students following a loss event. Journal of Community Psychology, 1993, 21, 83-96

Williams, K. (1997). Preventing suicide in young people: what is known and what is needed. Child: Care, Health And Development, 1997, 23, 173-185

Williams, M. (1997). Cry of Pain: Understanding suicide and self-harm. Penguin Books, London, 1997

Wolk-Wasserman, D. (1987). Contacts of suicidal neurotic and prepsychotic/psychotic patients and their significant others with public care institutions before the suicide attempt. Acta Psychiatrica Scandinavica, 1987, 75, 358-372

Woodroofe, C., Glickman, M., Barker, M., & Power, C. (1993). Children, teenagers and health: The key data. Open University Press, Milton Keynes

World Health Organisation (1989-1995). World Health Statistics Annuals. Geneva: WHO.

2. Major Research Project Proposal

Applicants

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1. Title

Social Support And Help-Seeking in Parasuicide versus Depression in Young Adults

2. Summary

Research is proposed to investigate differences in perceptions of social support and levels of help-seeking behaviour between parasuicidal and depressed groups of patients in a young adult population. Previous studies have suggested that parasuicidal patients may report lower levels of perceived social support. Other studies have suggested that a high proportion of suicide attempters have contact with medical services prior to a parasuicidal act, but may not discuss their feelings or plans, and thus fail to access support. It is also intended to investigate the association between feelings of shame and guilt and psychopathology in a clinical population. There is some evidence from non-clinical populations that feelings of shame may be higher in a parasuicidal population and that these feelings could serve as a barrier to accessing support. However, these associations have not yet been assessed in a clinical population. It may be possible to identify and target those individuals at greatest risk for engaging in suicidal behaviour and to identify some factors preventing them from engaging in help-seeking behaviour.

Parasuicide participants will be drawn from those admitted to hospital within Glasgow, with a depressed control group recruited via Community Mental Health Teams and Clinical Psychology Departments within Glasgow. Participants will be assessed with regard to their perceptions of social support, levels of active help-seeking behaviour, and reported feelings of shame and guilt.

3. Introduction

There has been a marked increase in suicide attempts and completed suicides amongst young people over the last 20 years. In many developed countries, suicide is one of the leading causes of death among young people (World Health Organisation). This increase has been particularly marked amongst young men (Williams, 1997).

A number of factors have been shown to be associated with increased risk of suicidality, including: diagnosable mental disorder, being a psychiatric patient, previous self-destructive behaviour, male sex, unemployment, financial problems, physical illness, and substance abuse (Gunnell & Frankel, 1994; Rihmer, 1996; Appleby, 1992). Similarly, a number of factors have been suggested as particularly relevant to the increase in suicidal behaviour in young people. These include, an increase in substance abuse, more young people continuing to tertiary education, changes in the nuclear family, effects on the availability of positive role models, and interactions between social factors and childhood care. However, the factors underlying the increase in suicide rates are not clear and the investigation and prevention of suicidal behaviour remains a serious concern.

One factor which has been shown to be associated with suicide risk is a person's social support. Henderson (1981) suggested that what was most important was not the number of relationships but the person's perception of these. Neeleman & Power (1994) found that psychiatric groups reported lower levels of social support than did medical controls. They also suggested that deficiencies in social support may be most important in depressive disorders. Kralik & Danforth (1992) found that serious

suicidal ideators differed from attempters in the relative effectiveness that having social attachments has on preventing suicide behaviour.

Another factor relevant to suicidal behaviour is help-seeking behaviour by the individual prior to engaging in a suicidal act. Tousignant & Hanigan (1993) compared social support following a loss in two groups of suicidal or non-suicidal college students. They found that the suicidal group named fewer important persons in their kinship network and had more conflicts with this network than did the nonsuicidal group. The suicidal group was also less ready to inform the network about the loss event. Thus, perceptions of social support may affect an individual's ability to seek support and assistance at a time of particular difficulty.

Suicide attempters may also try to seek assistance from health professionals. Hintikka et al (1998) found that 92% of individuals who had displayed suicidal behaviour during the previous 12 months had had some contact with health-care services at the same time. However, the corresponding figure among non-suicidal individuals was 90% suggesting that it is important to find a way to identify those at greatest risk. Michel et al (1997) have suggested that many patients may be reluctant to discuss suicidal feelings with their doctor, creating a discrepancy between the potential role of medical practitioners in the prevention of suicide and daily practice.

A third factor, which may be relevant to both social support and help-seeking behaviour in parasuicide is that of shame. It is suggested that feelings of shame and guilt are associated with feelings of depression and increased psychopathology (Tangney, 1991; Tangney, 1992; Gilbert et al, 1994; Lester, 1997). Shame may be

particularly relevant to suicidal behaviour (Lester 1997, 1998). Important distinctions have been made between the affective states of shame and guilt. Particularly important is that in guilt the focus is on a particular behaviour while shame encompasses the entire self.

Lester (1997) suggested that the role of shame has been neglected as a motivating factor in suicide. Because of their global nature, feelings of shame can be particularly devastating and also work to prevent the potentially suicidal person seeking support and assistance. However, studies in this area so far, have been carried out using non-clinical populations.

It seems likely that there may be differences in perceptions of social support and engagement in help-seeking behaviour between suicidal and non-suicidal individuals. It also seems likely that suicidal individuals experience higher levels of feelings of shame and that these feelings could contribute to difficulties in seeking help from either formal or informal sources of support.

The aim of this study is to investigate differences in perceptions of social support and willingness to seek help between suicidal and depressed patients, and also to investigate the possible association between feelings of shame or guilt and depression and suicidal behaviour in a clinical population.

4. Hypotheses to be tested

Hypothesis 1 - Participants within an identified parasuicidal group will perceive their social support as significantly less satisfactory than participants within a clinically depressed but non-suicidal group.

Hypothesis 2 - Participants within the parasuicidal group will be significantly less likely to engage in help-seeking behaviour from either formal or informal sources than participants within the depressed group.

Hypothesis 3 – Participants within the parasuicide group will score significantly higher than depressed controls on a measure of shame.

Hypothesis 4 – There will be no significant difference between the parasuicide group and depressed controls on a measure of guilt.

5. Plan of Investigation

5.1 Participants Participants will be within the age range 18 to 30 years. It is intended to exclude patients with serious drug or alcohol dependency. Participants will be recruited into two groups:

(i) Parasuicide group- recruited via Accident & Emergency following an attempt at deliberate self-harm that would constitute a risk to life or appears to have been intended to endanger the person's life.

(ii) Depressed group – recruited via Community Mental Health Teams or Clinical Psychology departments and with a primary diagnosis of clinical depression but no known history of parasuicidal behaviour within the last 6 months. As the parasuicide group may not have ongoing contact with services the depressed participants will

have been seen at the CMHT or Psychology department for the first time within the last two weeks.

5.2 Measures – All participants will be asked to complete the following measures:

(i) The Significant Others Scale (SOS) (Power Champion & Aris, 1988; Power & Champion, 1992). The SOS is designed to measure participants' perceptions of the social support they receive. The scale provides actual and ideal ratings of emotional and practical support.

(ii) Measure of Help-Seeking behaviour. A behaviourally defined measure developed for this study. Participants will be asked to estimate the amount of contact with their support network versus the number of times they sought to discuss difficulties with that network in relation to eight categories of possible support: spouse/partner; close friend; family; GP; telephone support service; voluntary support group; mental health professional (e.g. CPN or Psychologist); psychiatrist. (see Appendix 2).

(iii) Test of Self-Conscious Affect (TOSCA) Tangney, Wagner & Gramzow, 1992). A scenario-based measure giving indices of shame, guilt, externalisation, detachment/unconcern, alpha pride (pride in self) and beta pride (pride in behaviour).

(iv) Beck Depression Inventory (BDI) Beck, Ward, Mendelson, Mock & Erbaugh, 1961). A 21-item self-report questionnaire providing an estimate of severity of depression.

(v) Beck Hopelessness Scale (BHS) Beck, Weissman, Lester & Trexler, 1974). A 20-item self-report scale providing an estimate of participants level of hopelessness.

(vi) Risk Factor Assessment measure - Developed for the purpose of this study to provide an estimate of the presence/absence of known risk factors for parasuicidal behaviour. (see Appendix 2)

5.3 Design and Procedure. This study will be a between groups design with two independent groups. A number of power calculations based on previous related studies were carried out using UCLA – Power Calculator to determine appropriate sample size. These calculations suggested groups of between 17 and 44 participants in each group. However a number of studies were carried out with non-clinical populations or groups matched on a measure of depression, which may necessitate larger groups to detect significance It is suggested that a minimum of 35 participants should be recruited into each group in the proposed study.

The parasuicide group will be identified via A&E and contacted while in hospital to provide them with a patient information sheet and invite them to take part in the study. It is intended to contact the person within three days, and for the data collection interview to be carried out within one week, of presenting at A&E. The depressed group will be identified via referrals to the psychology department or CMHT. Potential participants will be contacted to provide them with information regarding the study and invite them to take part. Participants will be contacted as soon as possible after referral with the interview completed within the period of the first two treatment sessions.

5.4 Data collection and analysis. – Data from both groups will be collected via semi-structured interview using the measures detailed above. It is intended to complete all measures within one interview lasting approximately 1½ hours. The interview may be completed in more than one session if necessary. Data will be stored and processed using alphanumeric codes to ensure anonymity. The data will be analysed to test for

differences between the groups in (1) perceptions of social support, (2) active help-seeking behaviour, (3) ratings of shame and guilt. The differences between groups will be examined using a test for independent samples.

5.5 Settings and equipment. It is anticipated that in the case of the parasuicidal group most interviews will be completed within the hospital setting. On some occasions the interview may take place within the participants own home if their admission has been brief. Interviews with participants within the depressed group will take place either within their home or within a psychology department or CMHT base where possible. The equipment used will consist primarily of the measures identified above. The data will be analysed using the statistical package SPSS for windows.

6. Practical applications.

The literature to date suggests that a person's level of social support, or their perception of their social support is related to their risk of engaging in suicidal behaviour. Thus, those who perceive themselves to have inadequate levels of social support may represent a group at increased risk of suicide. Their experience of available support may also affect their willingness to engage in help-seeking behaviour of any sort, including from medical services. Many of those who engage in suicidal behaviour are also in contact with medical services prior to their suicidal act but may be unwilling to ask directly for help. A better understanding of the role of social support and help-seeking behaviour in suicide may help in the identification of those who are seeking help indirectly and allow for the provision of appropriate services.

Data from non-clinical populations suggest that people scoring highly on a measure of shame-proneness may be at greater risk of subsequent suicidal behaviour. These people may also be reluctant to engage in direct help-seeking behaviour. If this relationship can be confirmed in a clinical population it may help to identify a group at particular risk of suicidal behaviour.

7. Timescales

It is anticipated that recruitment sites will be identified and ethical approval submissions carried out between April and June 1999, with recruitment beginning in July 1999. Recruitment will be carried out between July 1999 and April 2000. Data analysis and report writing should commence in May 2000.

8. Ethical Approval

Ethical approval will be necessary and will be sought once likely recruitment sites have been confirmed. It is hoped to carry out all research within the Greater Glasgow Area. Glasgow Royal Infirmary and the Glasgow Western Infirmary have been identified as potential recruitment sites and have been contacted with regard to recruitment. Ethical approval will be sought from Glasgow Primary Care NHS Trust with respect to recruitment of participants in the depressed group.

Addendum

Provisional Ethical Approval was received from Glasgow Western Infirmary in July 1999 and confirmed in September 1999. Ethical approval was received from Glasgow Primary Care Trust in August 2000. Participant recruitment began in November 1999 and continued until June 2000. Participants were recruited via Glasgow Western Infirmary, Shawpark CMHT and Leverndale and Stobhill Clinical Psychology Departments.

References

Appleby, L. (1992). Suicide in psychiatric patients: risk and prevention. British Journal of Psychiatry, 1992, 161, 749-758

Gilbert, P., Pehl, J., & Allan, S. (1994). The phenomenology of shame and guilt: An empirical investigation. British Journal of Medical Psychology, 1994, 67, 23-36

Gunnell, D., & Frankel, S. (1994). Prevention of suicide: aspirations and evidence. British Medical Journal, 1994, 308, 1227-1233

Henderson, S., Byrne, D.G. & Duncan Jones, P. (1981). Neurosis and the social environment. Sydney, Academic Press.

Hintikka, J., Viinamaki, H., Tanskanen, A., Kontula, O. & Koskela, K. (1998). Suicidal ideation and parasuicide in the Finnish general population. Acta Psychiatrica, Scandinavica, 1998, 98, 23-27

Johnson, R.C., Danko, G.P., Huang, Y.H., Park, J.Y., Johnson, S.B.,
& Nagoshi, C.T., (1987). Guilt, shame and adjustment in three cultures. Personality and Individual Differences, 1987, 8, 357-364.

Kralik, K.M. & Danforth, W.J. (1992). Identification of coping ideation and strategies preventing suicidality in a college-age sample. Suicide & Life-Threatening Behavior, 1992, 22, 167-186

Lester, D. (1997). The role of shame in suicide. Suicide and Life-Threatening Behavior, 1997, Vol. 27, 352-361

Lester, D. (1998). The association of shame and guilt with suicidality. The Journal of Social Psychology, 1998, 138, 535-536

Lewis, H.B. (1971). Shame and guilt in neurosis. New York: International Universities Press

Michel, K., Runeson, B., Valach, L &., Wasserman, D. (1997). Contacts of suicide attempters with GP's prior to the event: a comparison between Stockholm and Bern. Acta Psychiatrica Scandinavica, 1997, 95, 94-99

Neeleman, J. & Power, M.J. (1994). Social support and depression in three groups of psychiatric patients and a group of medical controls. Social Psychiatry & Psychiatric Epidemiology, 1994, 29, 46-51

Rey Gex, C., Narring, F., Ferron, C. & Michaud, P.-A. (1998). Suicide attempts among adolescents in Switzerland: prevalence, associated factors and co-morbidity. Acta Psychiatrica Scandinavica, 1998, 98, 28-33

Rihmer, Z. (1996). Strategies of suicide prevention: Focus on health care. Journal of affective Disorders, 1996, 36, 83-91

Seligman, M.E.P., Abramson, L.Y., Semmel, A., & von Baeyer, C. (1979). Depressive Attributional Style. Journal of Abnormal Psychology, 1979, 88, 242-247

Tangney, J.P. (1991). Moral affect: The good, the bad, and the ugly. Journal of Personality and Social Psychology, 1991, 61, 598-607

Tangney, J.P., Wagner, P., and Gramzow, R. (1992). Proneness to shame, proneness to guilt and psychopathology. Journal of Abnormal Psychology, 1992, 101, 469-478.

Tousignant, M. & Hanigan, D. (1993). Crisis support among suicidal students following a loss event. Journal of Community Psychology, 1993, 21, 83-96

Williams, K. (1997). Preventing suicide in young people: what is known and what is needed. Child: Care, Health And Development, 1997, 23(2), 173-185

World Health Organisation (1989-1995). World Health Statistics Annuals. Geneva: WHO.

3. MAJOR RESEARCH PROJECT PAPER

Social Support and Help-Seeking

in Parasuicide versus Depression

in Young Adults

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Written in accordance with guidelines for submission to

British Journal of Clinical Psychology (Appendix 3)

Abstract

Objective This research examined: (a) if parasuicide patients would perceive their social support as less satisfactory than depressed controls; (b) if parasuicide patients would be less likely to engage in help-seeking behaviours than depressed controls; and (c) if parasuicide patients would score more highly on the shame component, but not the guilt component, of a measure of shame and guilt than a depressed control group, within a young adult population.

Design An independent, between groups design was used which compared two groups (parasuicide patients and depressed controls) on measures of social support, help-seeking, and a measure of shame and guilt.

Methods 19 parasuicide patients aged 18 to 30 years were recruited after admission to hospital following a non-fatal suicide attempt. They were compared with 17 depressed patients with no recent history of parasuicidal behaviour, aged 18 to 30. The main measures related to perceptions of social support, active help-seeking behaviour and a measure of feelings of shame and guilt.

Results No significant differences were found between the groups on the three main measures. The parasuicide group scored significantly higher on a measure of hopelessness but not depression

Conclusions The parasuicide and depressed groups appeared to show substantial overlap and may not represent truly independent experimental and control groups. The variables of social support, difficulties in help-seeking behaviour and shame and guilt may be related to significant psychopathology but do not appear to be sufficient to identify those at acute risk of suicidal behaviour.

Introduction

The prevention of suicidal behaviour had been identified as a priority area for health strategy in recent years (Health of the Nation, Department of Health, 1992; Our Healthier Nation, Secretary of State for Health, 1998). One area of concern has been the increase in suicide attempts and completed suicides among young people over the last 20 years, particularly among young males (Williams, 1997a). In many developed countries suicide is one of the leading causes of death among young people (World Health Organisation).

The reduction of suicide may not be an easy task. Individual factors such as diagnosable mental disorder, previous self-destructive behaviour, male gender, unemployment, financial problems, physical illness, substance abuse, acute life crisis, and access to means (Appleby, 1992; Brent, Perper, Moritz et al, 1993a, 1993b; Gunnell & Frankel, 1994; Rihmer, 1996; Shaffer, Garland, Gould, Fisher & Trautman, 1988; Williams, 1997b) have been shown to be associated with increased risk of suicidality. However, only a small proportion of those affected by even a combination of these variables will subsequently attempt or complete suicide and these factors do not in themselves easily suggest ways in which the risk of suicidality can be moderated.

A number of psychological factors have been shown to be relevant to suicidal behaviours, including: hopelessness (Beck, Brown, Berchick, Stewart, & Steer, 1990; Beck, Brown & Steer, 1989; Dyer & Kreitman, 1984; Petrie, Chamberlain & Clarke, 1988); positive future thinking (MacLeod, Pankhania, Lee & Mitchell, 1997;

MacLeod, Tata, Evans et al, 1998) problem-solving deficits (Linehan, Camper, Chiles, Strohsal & Shearin, 1987; Orbach, Bar-Joseph & Dror, 1990; Schotte & Clum, 1987;) and perceptions of social support (Bille-Brahe, 1996; Henderson, 1981, Kralik & Danforth, 1992; Magne-Ingvar, Ojehagen & Traskman-Bendz, 1992; Neeleman & Power, 1994). Understanding of these factors in relation to suicidal behaviour may indicate ways in which the risk of suicidality can be reduced.

This study looks at three factors believed to be related to suicidal behaviour: (i) social support, (ii) help-seeking behaviour, (iii) feelings of shame.

Neeleman & Power (1994) found that psychiatric groups reported lower levels of social support than did medical controls. Magne-Ingvar et al (1992) found that suicide attempters tended to have a less satisfactory social network than controls measured both objectively and subjectively. Perceptions of social support may be particularly important. In a sample of suicide attempters Bille-Brahe (1996) found that while the average amount of social support was high it was not equal to the level of need they experienced.

One way social support may moderate suicide risk is in relation to help-seeking behaviour. Tousignant & Hanigan (1993) found that a suicidal group named fewer important persons in, and had more conflict with, their kinship network than a control group. In addition, the suicidal group was less ready to inform their network about a loss event. Thus, perceptions of social support may affect an individual's ability to access support at a time of difficulty. Many suicide attempters may be in contact with a GP or mental health professional prior to a suicidal act but may fail to discuss

difficulties or feelings of suicidality (Hintikka, Viinamaki, Tanskanen, Kontula & Koskela, 1998; Michel, Runeson, Valach & Wasserman, 1997). It may be that suicide attempters experience particular difficulties in seeking help from either formal or informal sources.

One factor suggested as a potential barrier to seeking help is shame. It has been suggested that feelings of shame and guilt are associated with increased psychopathology (Gilbert, Pehl & Allan, 1994; Lester 1997; Tangney, 1991; Tangney, Wagner & Gramzow, 1992) and that shame may be particularly relevant to suicidal behaviour (Lester, 1997, 1998). A psychodynamic model of shame and guilt developed from Lewis (1971) conceptualises guilt as being focused on a particular behaviour (I did a bad thing), while shame encompasses the entire self (I am a bad person). If the entire self is evaluated negatively removal of the self may represent a resolution of the problem. In addition, the global, overwhelming nature of the feelings can make it difficult to seek help and support. Thus, in a more cognitive-behavioural model shame could be conceptualised as a global, negative, self-attribution which makes it difficult to seek support from others. However, studies in this area so far have used non-clinical populations.

There seems to be some evidence that perceptions of social support, levels of help-seeking behaviour, and feelings of shame are relevant to suicidal behaviour. There is also a particular concern regarding the marked increase in attempted and completed suicides in young people. The aim of this study is to investigate (1) perceptions of social support, (2) help-seeking behaviour (active behaviour compared to

opportunities to seek help, and (3) feelings of shame, in two groups of young adults – a parasuicide group and a depressed group.

It was hypothesised that:

1. The parasuicide group would perceive their social support as significantly less satisfactory than the depressed controls.

2. The parasuicide group would be significantly less likely to engage in help-seeking behaviour, from either formal or informal sources, than the depressed controls.

3. The parasuicide group would score significantly higher on the shame component of a measure of shame and guilt than the depressed controls.

4. There would be no significant difference between the parasuicide group and the depressed control group on the component of guilt.

Method

Participants

Two groups of participants were recruited.

(i) Parasuicide Group - Participants were admitted to an acute receiving ward via the Accident and Emergency Department at Glasgow Western Infirmary following an episode of deliberate self-harm. Participants were identified initially via admission category (e.g overdose/self-harm). They were then followed up to the admission ward and information was obtained via the receiving medical team as to whether the participant met the criteria for the study. Inclusion criteria were: aged between 18 and 30 years; episode of deliberate self-harm that would constitute a risk to life or appeared intended to endanger life. Participants with a serious drug or alcohol dependency were excluded. Information on possible drug/alcohol dependency was

gathered via the receiving medical team or, if necessary via medical personnel where the person was transferred to a psychiatric ward. There were 68 participants identified over the study period. These did not represent a consecutive sample but reflected practical issues arising from resources available to the research. Of these 68, 19 completed the interview, 4 refused, 10 gave verbal consent to participate but could not subsequently be contacted after leaving hospital, 18 took an irregular discharge or were transferred to other wards and could not be traced, and a further 17 could not be interviewed for a number of reasons, including too ill to be seen, did not attend for interview, or were transferred to other services. Of the 19 who completed the interview, 14 were female and 5 male. The age range was 19-30 with a mean of 24 years. The mean delay between parasuicide and taking part in this research was 3 days (range 1 – 7 days). No data was available regarding potential participants who did not take part in the study as permission had not been sought to access case notes to gather this information.

(ii) Depressed Group - Participants were recruited via a Community Mental Health Team and two Clinical Psychology Departments. Inclusion criteria were: aged between 18 and 30 years; primary diagnosis of depressive disorder; no known incident of parasuicidal behaviour within the last six months; participants to be seen while still on the waiting list for treatment or within the first three treatment sessions. Participants with a serious drug or alcohol dependency were excluded. There were 52 potential participants identified during the study period and contacted by letter. Of these 52, 17 subsequently completed the interview, 2 refused, 6 agreed but did not attend for interview, 26 did not reply and 1 person committed suicide. Of the 17 interviewed, 12 were female and 5 were male. The age range was 21-30 with a mean

age of 27. Data was not collected regarding potential participants who did not take part in the study as permission had not been sought to access case notes.

Measures

All participants completed the following measures:

(i) The Significant Others Scale (SOS) (Power Champion & Aris, 1988; Power & Champion, 1992) – The SOS is designed to measure participants' perceptions of the social support they receive. The scale provides actual and ideal ratings of emotional and practical support.

(ii) Measure of Help-Seeking behaviour – A behaviourally defined measure developed for this study. Participants were asked to estimate the amount of contact with their support network versus the number of times they sought to discuss difficulties with that network in relation to eight categories of possible support: spouse/partner; close friend; family; GP; telephone support service; voluntary support group; mental health professional (e.g. CPN or Psychologist); psychiatrist.

(iii) Test of Self-Conscious Affect (TOSCA) Tangney et al, 1992) - A scenario-based measure giving indices of shame, guilt, externalisation, detachment/unconcern, alpha pride (pride in self) and beta pride (pride in behaviour).

(iv) Beck Depression Inventory (BDI) Beck, Ward, Mendelson, Mock & Erbaugh, 1961) – A 21-item self-report questionnaire providing an estimate of severity of depression. Scores range from 0 to 63.

(v) Beck Hopelessness Scale (BHS) Beck, Weissman, Lester & Trexler, 1974) – A 20-item self-report scale providing an estimate of participants level of hopelessness. Scores range from 0 to 20.

(vi) Risk Factor Assessment measure - Developed for the purpose of this study to provide an estimate of the presence/absence of known risk factors for parasuicidal behaviour.

Procedure

(i) Parasuicide group - Participants were identified via A&E and contacted on the ward to give them information about the study within 24 hours of being admitted to hospital. Following the person giving informed consent, interviews were carried out either while the person was in hospital or shortly after discharge to their home or a psychiatric ward.

(ii) Depressed group – Participants from one Clinical Psychology department were identified from the waiting list where there was sufficient information in the referral letter to determine if the person met the criteria for the study. Participants from the other Clinical Psychology department and from the CMHT were identified after the person had been seen for an initial assessment interview. Potential participants from all three sites were contacted by letter to give them information about the study and asked to return a form indicating if they consented to be interviewed. Not all participants seen at the CMHT had been offered follow-up appointments. Those who were and those identified via clinical psychology were all seen either prior to beginning treatment or within three weeks of beginning treatment.

All participants were informed that the purpose of the study was to look at sources of support and help for people with differing emotional difficulties, with the intention of trying to understand what things may be difficult, and what sort of support would be helpful. The voluntary, confidential, and anonymous nature of the study was emphasised. Interviews were generally completed in one session but on three

occasions were completed over 2 sessions. At the time of the interview all participants appeared free of evidence of toxicological (drug) impairment. Following completion of the interview codes were attached to all measures and all identifiers were removed to ensure anonymity. The consent procedure, administration of the measures and debriefing took approximately one hour and fifteen minutes.

Design

The study was a between groups design with two independent groups. Power calculations based on previous relevant measures suggested minimum group sizes of 35 participants.

Results

The participants scores for each of the main measures are contained in Table 1.

Demographic Variables

The mean age was 24.42 (SD=3.15) and 27.12 (2.37) years for the parasuicide and depressed groups respectively. An independent t-test indicated that the parasuicide group was significantly younger than the depressed group ($t(34)=-2.88$, $p=0.007$).

Chi-square analyses indicated that there were no significant differences between the groups in terms of ratio of males: females (*FET=0.043 df=1.0, n.s.), or employment status ($\chi^2=2.97$, df=3 n.s.).

* FET = Fisher Exact Test

Significant Others Scale

The SOS gives scores for actual and ideal levels of emotional support and practical support. These scores are then used to calculate a measure of discrepancy between actual and ideal scores. Analysis showed that data for ideal emotional support and actual practical support were non-parametric in nature. These were analysed using Mann-Whitney U analysis, scores for the other 4 indices were analysed using independent t-tests. There was no significant difference between the groups in perceived discrepancy between actual and ideal support in relation to emotional support ($t(34)= -1.36$, $p= .18$) or practical support ($t(34)= -1.71$, $p= .10$). There was no significant difference between the groups on mean scores of actual or ideal emotional or practical support (emotional support/actual $t(34)= -.85$, $p= .4$; emotional support/ideal $U=133$, $p= .38$; practical support/actual $U= 132$, $p=.36$; practical support/ideal $t(34)=0.22$, $p= .83$).

Help-Seeking Behaviour

This measure gave scores for number of contacts with the persons support network (contact) compared to attempts to discuss difficulties with the network (discussion) across eight categories of formal and informal support. The score for discussion was divided by the score for contact to give an index of help-seeking behaviour for each category. Due to the non-parametric nature of the data Mann-Whitney U analyses were used to compare the groups in terms of help-seeking behaviour for each category. There were no significant differences between the groups in relation to any category of support: spouse/partner ($U= 46.5$, $p=.56$); close friend ($U=93.0$, $p=.32$); family ($U=116.0$, $p=.23$); GP ($U=87.5$, $p=.87$); voluntary support group ($U=0.5$,

p=.67); mental health professional (U= 4.0, p=.26); Psychiatrist (U=5.0, p=.17). It was not possible to carry out an analysis on telephone support as none of the parasuicide group and only two of the depressed group reported using this service.

Test of Self-Conscious Affect

The scores on the TOSCA were analysed using independent t-tests. There were no significant differences between the groups on the main measures of shame and guilt, (t(34)= 0.34, p= .74) and (t(34)= 0.30, p= .76) respectively. In addition, there were no significant differences between the groups on the other scores of externalisation (t(34)= -0.03, p= .98), detachment/unconcern (t(34)=0.63, p= .53), alpha pride (t(27)= 0.17, p= .87) and beta pride (t(34)=0.53, p= .60).

Beck Depression Inventory

Scores on the BDI were analysed using an independent t-test. There was no significant difference between the groups (t(34)=1.47, p=0.15).

Beck Hopelessness Scale

Due to the non-parametric nature of the data a Mann-Whitney U analysis was used to compare scores on the BHS. The parasuicide group scored significantly higher on this measure of hopelessness (U=99.0, p=.049).

Risk Factors

There were no significant differences between the groups on any of the risk factors assessed. These related to: diagnosis of a psychiatric disorder (self-reported)

*FET=3.78 p= .92; physical illness χ^2 = 0.22 df=1, p= .23; relationship difficulties *FET=1.15 p=.47; experience of suicide χ^2= 0.36 df=1, p= .55. All participants in both groups reported experiencing emotional difficulties. There were no differences between the groups in relation to use of alcohol (units) in a typical week U=158.5, p=.92, or in the last week U=159.0, p= .94. There were also no differences between the groups in use of drugs (number of drugs) U= 153.0, p= .75, or in the last week, U=158.0, p= .89.

Discussion

No significant differences were found on the measures of social support, help-seeking behaviour, or the components of shame and guilt, between the parasuicide and depressed groups in this sample. In addition, there was no significant difference between the groups on the measure of depression (BDI). However the parasuicide group did have significantly higher scores on the measure of hopelessness (BHS). This is in accordance with the finding that feelings of hopelessness are particularly relevant to suicidal behaviour independent of severity of depression (Beck, Brown & Steer, 1989; Dyer & Kreitman, 1984; Petrie, Chamberlain & Clarke, 1988).

The lack of differences between the parasuicide and depressed groups may be due to several reasons. These include: the nature of the two samples, the power to detect differences from these samples, and the nature of the measures themselves.

* FET = Fisher Exact Test

Firstly, in considering the nature of the samples recruited, it should be noted that there were difficulties in recruiting participants to both groups. In the parasuicide group only 28% of those identified as suitable subsequently completed the interview while within the depressed group this figure was 33%. This appeared to reflect both practical difficulties in relation to the resources available to the study, and also difficulties in carrying out research with these groups. However it does raise a question as to whether those participants recruited to the study are truly representative of parasuicide or depressed patients as a whole. It may be that only a particularly compliant subset were willing to take part in the research.

Secondly, it is possible that the difficulties with recruitment and compliance may have resulted in insufficient power to detect significant differences between the groups. There were difficulties in estimating the appropriate size of groups to detect significant differences. Power calculations carried out before recruitment began estimated group sizes between 17 and 44 participants. However these calculations were based on studies believed to be relevant but which were not directly comparable e.g. similar populations but a different measure of help-seeking behaviour (Botsis, Soldatos, Liossi, Kokkevi & Stefanis, 1994) while the TOSCA had not previously been used within a clinical population. Post-hoc power calculations were carried out using the data obtained in this study to estimate the size of groups necessary to detect significant differences. On the SOS these calculations suggested groups of 56 (parasuicide) and 67 (depressed) on the component of discrepancy in emotional support, and 44 (parasuicide) and 31 (depressed) on the component of discrepancy in practical support. Similar numbers were estimated to detect differences in help-seeking behaviour on the components of friends or family. There was some

suggestion that relatively small groups would be necessary to detect differences in help-seeking behaviour from mental health professionals(17-parasuicide, 10-depressed) and psychiatrist (9-parasuicide, 7-depressed), but as very few of the participants had contact with these professionals this is difficult to estimate. Extremely large groups (800+) would be necessary to detect significant differences between the groups on the shame component of the TOSCA. Thus, the non-significant results in this study do appear to be at least partially due to insufficient power due to the difficulties in recruiting the estimated numbers of participants.

A further difficulty is that, rather than representing independent experimental and control groups as intended, the two groups may in fact be drawn from very similar populations. Thus it may be that no differences between the groups were detected as the differences between the groups are relatively small. However, both groups may then differ on these measures from a sample drawn from the community. There is some evidence that this explanation may be partially true. Although a difference was noted between the groups on the BHS, the mean sores for both groups, parasuicide 14.42 (SD 5.80) depressed 11.47 (SD 4.94) were higher than would be expected in the general population, 4.45 (SD 3.09) (Greene, 1981). The scores for both groups on the BDI (parasuicide – 29.89, depressed – 24.24) fell with the moderate to severe range. This suggests that these groups can be regarded as both experiencing significant psychological distress and thus might be expected to display certain similarities on measures of psychological functioning. This is difficult to assess in the absence of a control group drawn from the general population. However it is possible to explore this, at least partially, in relation to the TOSCA. Some data were available from Tangney (personal communication) detailing scores on the TOSCA from a variety of

non-clinical samples (see Appendix 4). The scores obtained on the measures of shame and guilt from the two groups in this study were compared with college students from a large public university receiving credit for a psychology course requirement (GMU90F). On the component of shame there was a significant difference between the combined groups in this study (mean - 51.80, SD - 0.88) and the combined student sample (mean – 41.35, SD – 0.98) $t(2)=11.23$, $p= .008$. On the component of guilt there was no difference between the combined groups in this study (mean - 59.90, SD – 0.52) and the combined student sample (mean – 57.73, SD 1.94) $t(1.14)=1.53$, $p= .35$. These comparisons may provide some evidence to support the suggestion that no significant differences were obtained on the main measures because the parasuicide and depressed control groups are not separate groups but rather show substantial overlap.

The evidence that there may be substantial overlap between the two groups highlights a major difficulty with this study. The study is designed as a study of two independent groups, a parasuicide group and a depressed control group. The groups are differentiated with respect to recent parasuicidal behaviour in that the parasuicide group were interviewed shortly after a parasuicidal incident while the depressed group were required to have shown no incident of parasuicidal behaviour in the last six months (in practice two years). However this does not preclude the depressed group experiencing, for example, suicidal ideation. As such, the two groups may have been less differentiated than anticipated in terms of aspects of psychopathology. The study may have benefited from the inclusion of a more non-psychopathological group drawn from the general population. This would provide an indication of normal psychological functioning in terms of the measures used. This might provide an

indication as to whether the two experimental groups are differentiated from the general population. Alternatively, previous studies (e.g. Neeleman & Power, 1994) have used a control group drawn from a medical population. A group drawn from this population allows for some disruption to normal functioning but which is not related to specifically psychological factors.

A further reason for the lack of significant differences between the groups may be the characteristics of the measures used in this study. There was reasonable face validity for using the TOSCA as the components of shame and guilt appeared to be differentially related to measures of psychopathology within an undergraduate population (Tangney et al, 1992). However the measure had not previously been used within a clinical population. The evidence from this study suggests that, while the shame component in particular may be related to generally increased psychopathology, it is not clear how this relates to differing levels of psychopathology. In a study by Neeleman & Power (1994) it was possible to differentiate between psychiatric patients and medical controls using the SOS, although it did not appear to differentiate between parasuicide and depressed groups of patients. However the authors noted that the relatively small numbers in these groups (N=26) may have limited the power of these tests. As it had been intended to recruit larger groups of participants it seemed possible that significant differences might be detected in this study. However insufficient numbers of participants were recruited to investigate this possibility. The measure of help-seeking behaviour was devised for the purpose of this study and was untended to investigate the difference between opportunities for seeking support and capacity/willingness to act on these opportunities. The lack of significant results suggests that this may not be sufficiently sensitive to differentiate between the groups with respect to help-seeking behaviour.

A difficulty may be that this measure examines reports of overt behaviour. It may be that it would be more helpful to consider whether the participants felt the index of help-seeking behaviour calculated matched their need, e.g. did the person feel they sought help whenever they needed to or did they want to ask for more help but felt they could not. This may be more likely to assess relevant psychological aspects of help-seeking behaviour.

Conclusions

No significant differences were found between the parasuicide and depressed groups on the main measures of social support, help-seeking behaviour, and shame and guilt. A significant difference was detected between the groups on a measure of hopelessness. This finding of hopelessness being strongly related to suicidal behaviour has been well documented in a number of other studies (Beck et al,1989, 1990; Dyer & Kreitman, 1984; Petrie et al, 1988) and helps to confirm that the failure to find significant differences on the other measures is not purely due to insufficient participants being recruited.

The failure to find significant differences on the main measures illustrates some of the difficulties in identifying those most at risk of suicide. None of the participants in the depressed group had shown recent parasuicidal behaviour and none were considered at high risk for suicidal behaviour in the near future. Despite this these patients could not easily be differentiated from a parasuicidal group on measures believed to be relevant to suicidal behaviours. The variables of social support, difficulties in help-seeking behaviour and shame and guilt may be related to significant psychopathology

or psychological distress per se but not necessarily, in this sample, related to an increased risk of suicidality.

Table 1. Participant Scores for Main Variables

Variable *Mean (SD) / Median (IQ range)	Parasuicide Group (N=19)	Depressed Group (N=17)
1. Significant Others Scale		
Emotional support - discrepancy Mean (SD)	-3.04 (1.43)	-2.33 (1.72)
Practical support – discrepancy Mean (SD)	-2.51 (1.69)	-1.67 (1.17)
Emotional support – actual Mean (SD)	9.10 (1.81)	9.58 (1.57)
Emotional support – ideal Median (IQ range)	12.50 (11.29 – 13.14)	12.33 (11.43 – 12.57)
Practical support – actual Median (IQ range)	8.29 (6.00 – 9.71)	8.50 (7.69 – 10.10)
Practical support – ideal Mean (SD)	10.41 (2.06)	10.28 (1.33)
2. Help-Seeking Behaviour		
Spouse – ratio Median (IQ range)	0.30 (0.00 – 0.75)	0.01 (0.00 – 1.00)
Friend – ratio Median (IQ range)	0.50 (0.004 – 1.00)	0.34 (0.00 – 0.50)
Family – ratio Median (IQ range)	0.003 (0.00 – 0.29)	0.27 (0.00 – 0.65)
GP – ratio Median (IQ range)	1.00 (0.19 – 1.00)	1.00(0.25 – 1.00)

* SD = Standard Deviation, IQ range = Inter Quartile Range

Telephone support - ratio Median (IQ range)	None used	0.00 (0.25 – 1.00)
Voluntary group –ratio Median (IQ range)	0.005 (0.00 – 0.01)	0.00 (range not available)
Mental health professional – ratio Median (IQ range)	0.38 (0.00 – 0.93)	1.00 (0.50 – 1.00)
Psychiatrist – ratio Median (IQ range)	0.00 (0.00 – 0.75)	1.00 (0.75 – 1.00)
3. TOSCA		
Shame - Mean (SD)	52.42 (9.90)	51.18 (12.26)
Guilt - Mean (SD)	60.26 (7.32)	59.53 (7.17)
Externalisation - Mean (SD)	38.63 (7.50)	38.71 (6.28)
Detachment/unconcern - Mean (SD)	28.47 (7.21)	27.06 (6.14)
Alpha pride - Mean (SD)	15.95 (3.36)	15.71 (5.02)
Beta pride - Mean (SD)	16.68 (3.45)	16.06 (3.63)
4. Beck Depression Inventory (BDI) Mean (SD)	29.89 (12.13)	24.24 (10.74)
5. Beck Hopelessness Scale (BHS) Median (IQ range)	16.00 (12.00 – 19.00)	12.00 (8.00 – 15.00)

References

Appleby, L. (1992). Suicide in psychiatric patients: risk and prevention. British Journal of Psychiatry, 1992, 161, 749-758

Beck, A.T., Brown, G., Berchick, R.J., Stewart, B.L & Steer, R.A. (1990). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. American Journal of Psychiatry, 1990, 147, 190-195.

Beck, A.T., Brown, G. & Steer, R.A (1989). Prediction of eventual suicide in psychiatric inpatients by clinical ratings of hopelessness. Journal of Consulting and Clinical Psychology, 1989, 57, 309-310.

Beck, A.T, Ward, C.H., Mendelson, M., Mock, J. & Erbaugh, J. (1961). An inventory for measuring depression. Archives of General Psychiatry, 4, 561-571.

Beck, A.T., Weissman, A., Lester, D. & Trexler, L. (1974). The measurement of pessimism: The hopelessness scale. Journal of consulting and Clinical Psychology, 42, 861-865.

Bille-Brahe, U. (1996). Measuring social integration and social support Nordic Journal of Psychiatry, 1996, 50(37), 41-46

Botsis, A.J., Soldatos, C.R., Liossi, A., Kokkevi, A. & Stefanis, C.N. (1994). Suicide and violence risk I: Relationships to coping styles. Acta Psychiatrica Scandinavica, 1994, 89, 92-96.

Brent, D.A., Perper, J.A., Moritz, G., et al, (1993a). Psychiatric risk factors for adolescent suicide: a case-control study. Journal of the American Academy of Child and Adolescent Psychiatry, 32, 521-529

Brent, D.A., Perper, J.A., Moritz, G., et al, (1993b). Suicide in adolescents with no apparent psychopathology Journal of the American Academy of Child and Adolescent Psychiatry, 32, 494-500

Department of Health (1992). Health of the Nation. White Paper, London: Author

Dyer, J.A. & Kreitman N. (1984). Hopelessness, depression and suicidal intent in parasuicide. British Journal of Psychiatry, 1984, 144, 127-133

Gilbert, P., Pehl, J., & Allan, S. (1994). The phenomenology of shame and guilt: An empirical investigation. British Journal of Medical Psychology, 1994, 67, 23-36

Greene, S.M., (1981) Levels of measured hopelessness in the general population. British Journal of Clinical Psychology, 1981, 20, 11-14.

Gunnell, D., & Frankel, S. (1994). Prevention of suicide: aspirations and evidence. British Medical Journal, 1994, 308, 1227-1233

Henderson, S. (1981). Social relationships, adversity and neurosis: An analysis of prospective observations. British Journal of Psychiatry, 1981, 138, 391-398

Hintikka, J., Viinamaki, H., Tanskanen, A., Kontula, O. & Koskela, K. (1998). Suicidal ideation and parasuicide in the Finnish general population. Acta Psychiatrica, Scandinavica, 1998, 98, 23-27

Kralik, K.M. & Danforth, W.J. (1992). Identification of coping ideation and strategies preventing suicidality in a college-age sample. Suicide & Life-Threatening Behavior, 1992, 22, 167-186

Lester, D. (1997).The role of shame in suicide. Suicide and Life-Threatening Behavior, 1997, Vol. 27, 352-361

Lester, D. (1998). The association of shame and guilt with suicidality. The Journal of Social Psychology, 1998, 138(4), 535-536

Linehan, M.M., Camper, P., Chiles, J.A., Strohsal, k. & Shearin, E.N. (1987). Interpersonal problem solving and parasuicide. Cognitive Therapy and Research, 11, 1-12.

MacLeod, A.K., Pankhania, B. Lee, M. & Mitchell, D. (1997). Parasuicide, depression and the anticipation of positive and negative future experiences. Psychological Medicine, 1997, 27, 973-977.

MacLeod, A.K, Tata, P., Evans, K. Tyrer, P., Schmidt, U., Davidson, K., Thornton, S & Catalan, J. (1998). Recovery of positive future thinking within a high-risk parasuicide group: Results from a pilot randomized controlled trial. British Journal of Clinical Psychology, 1998, 37, 371-379.

Magne-Ingvar, U., Ojehagen, A., & Traskman-Bendz, L. (1992). The social network of people who attempt suicide. Acta Psychiatrica Scandinavica, 1992, 86, 153-158

Michel, K., Runeson, B., Valach, L &., Wasserman, D. (1997). Contacts of suicide attempters with GP's prior to the event: a comparison between Stockholm and Bern. Acta Psychiatrica Scandinavica, 1997, 95, 94-99

Neeleman, J. & Power, M.J. (1994). Social support and depression in three groups of psychiatric patients and a group of medical controls. Social Psychiatry & Psychiatric Epidemiology, 1994, 29(1), 46-51

Orbach, I., Bar-Joseph, H. & Dror, N. (1990). Styles of problem solving in suicidal individuals. Suicide and Life-Threatening Behaviours, 20, 56-64.

Petrie, K., Chamberlain, K., & Clarke, D. (1988). Psychological predictors of future suicidal behaviour in hospitalized suicide attempters. British Journal of Clinical Psychology, 27, 247-257.

Power, M.J. & Champion, L.A. (1992) The Significant Others Scale (SOS). In Milne D. (Ed.)Assessment: A mental health portfolio (pp.18-29). NFER-Nelson, Windsor

Power, M.J., Champion, L.A., & Aris, S.J., (1988). The development of a measure of social support: The Significant Others Scale. British Journal of Clinical Psychology, 1988, 27, 349-358

Rihmer, Z. (1996). Strategies of suicide prevention: Focus on health care. Journal of Affective Disorders, 1996, 36, 83-91

Secretary of State for Health (1998). Our Healthier Nation: A contract for health. Green Paper. London:Author.

Schotte, D.E. & Clum, G.A. (1987). Problem-solving skills in suicidal psychiatric patients. Journal of Consulting and Clinical Psychology, 55, 49-54

Shaffer, D., Garland, A., Gould, M., Fisher, P., & Trautman, P. (1988). Preventing teenage suicide: a critical review. Journal of the American Academy of Child and Adolescent Psychiatry, 1988, 27, 675-687.

Tangney, J.P. (1991). Moral affect: The good, the bad, and the ugly. Journal of Personality and Social Psychology, 1991, 61, 598-607

Tangney, J.P., Wagner, P., and Gramzow, R. (1992). Proneness to shame, proneness to guilt and psychopathology. Journal of Abnormal Psychology, 1992, 101(3), 469-478.

Tousignant, M. & Hanigan, D. (1993). Crisis support among suicidal students following a loss event. Journal of Community Psychology, 1993, 21(2), 83-96

Williams, K. (1997b). Preventing suicide in young people: what is known and what is needed. Child: Care, Health And Development, 1997, 23(2), 173-185

Williams, M. (1997a). Cry of Pain: Understanding suicide and self-harm . Penguin Books, London, 1997

World Health Organisation (1989-1995)
World Health Statistics Annuals. Geneva: WHO.

4. SMALL SCALE SERVICE EVALUATION PROJECT

Assessment of Priorities for Establishment of a

Clinical Psychology Service to a Psychiatric Service.

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Written in accordance with guidelines for submission to

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Summary

This paper describes a recent study which investigated the perceived priorities for psychological input to a hospital based psychiatric service prior to the establishment of a formal psychology service. Qualitative and quantitative data were collected with regard to 12 clinical activities across four categories of patients. The results obtained suggested a wide range of views on the role of clinical psychology within a psychiatric service. This may reflect some uncertainty as to the type of services clinical psychology can offer in this setting. Implications for establishment and subsequent audit of this service are discussed.

Introduction

Multi-disciplinary working has become an increasingly important aspect of clinical psychology services in recent years. There has been a shift from a traditional primary care role to work within Community Mental Health Teams, Psychiatry, Rehabilitation Services, and more general medical and health services [1,2,3,4,5]. In developing these new ways of working, a number of different models of service provision have emerged, and these are then tailored to the needs of the individual service. This has resulted in Clinical Psychology working through a wide range of activities and at a number of levels of service provision. Clinical Psychologists have been described as having a unique contribution to make to multi-disciplinary healthcare by virtue of specialist skills and training [6]. Within a psychiatric rehabilitation setting [1] important activities for clinical psychologists were identified as:

1. Assessment – of the individual, the environment, and the service
2. Therapy – with individual patients, working with staff of other disciplines, through the organisation, and providing a philosophy of care
3. Research – testing observations from clinical practice, developing a theory of rehabilitation, and linking theory to practice.
4. Teaching – both formally and informally.

However, given that Clinical Psychology is generally perceived as a scarce resource within the NHS, there has also been an emphasis placed on appropriate assessment and auditing of services to ensure that psychological input is effectively targeted and implemented [7,8].

At the time of this study, no formal Clinical Psychology input was established within the psychiatric service studied. Given that, once a formal service was established it was to be provided within the parameters of the funded establishment of 0.3 sessions (wte.), it was important to establish the most effective ways of providing this input. Assessment prior to implementation of a service would also allow a baseline measure of priorities to be established, against which any future service provision could be audited.

The aims of this study then were to:

(i) Assess perception of the role of clinical psychology within a psychiatric service.

(ii) Establish priorities for clinical psychology input to this service.

In doing this, 12 clinical activities were identified and perceptions of their usefulness rated by medical and nursing staff from the psychiatric service with regard to four broad categories of participants.

Clinical Activities

1. Assessment of individual patients
2. Neuropsychological assessment
3. Therapy for individual participants
4. Group therapy
5. Monitoring of recurrent symptoms
6. Couple/Family Therapy
7. Monitoring of psychological aspects of medicine/health related issues
8. Supervision of psychiatric trainees – SHOs and GPs in training

9. Supervision of other psychiatric staff

10. Teaching

11. Training

12 Consultancy/case discussion

Categories of Patients:

1. Affective Disorders and Sexual Abuse - e.g. Anxiety, Depression, Phobias, Obsessive-Compulsive disorder, Post-Traumatic Stress Disorder, Sexual Abuse, Adjustment disorders.

2. Psychotic Disorders - e.g. Schizophrenia, Schizoaffective disorder, Bi-polar disorder, Delusional disorders, Non-organic psychosis

3. Personality Disorders - e.g. Paranoid personality disorder, schizotypal personality disorder, borderline personality disorder.

4. Organic Disorders - e.g. Dementia - due to Alzheimer's, Huntington's, Parkinson's, HIV, CJD

Methods

Participants

Sixteen members of the Psychiatric Service participated in the study. These consisted of: 6 Consultant Psychiatrists, 2 Specialist Registrars, 4 Senior House Officers and 4 members of the senior nursing staff - 1 Clinical Nurse Manager and 3 Senior Charge

Nurses. In addition 2 further members of staff, 1 senior registrar and 1 clinical assistant were contacted regarding the study but were unable to participate due to other commitments.

Materials

Data was collected using a semi-structured interview which addressed both quantitative and qualitative assessment of the role of clinical psychology within the psychiatric service (see Appendix 6). The participants were asked to rate the usefulness of 12 identified clinical activities, using the scale 0% - not a useful activity to 100% - most useful activity, with regard to four broad categories of patients. From these ratings the activities identified as most and least useful within each category were identified and followed up by qualitative assessment of how these activities were or were not perceived as useful. The participants were also asked how they perceived the role of clinical psychology in general with regard to that category of patients.

Following assessment of each of the four categories of patients, the participants were asked, in general, if there were any activities they felt would be helpful that hadn't been mentioned, and how they viewed psychological input to the Psychiatry service overall. These and any other comments were recorded.

To assist with the interview procedure, participants were provided with an orientation sheet (see Appendix 6) which detailed the rating scale used, the four categories of patients, and the twelve clinical activities identified.

Procedure

Initially all potential participants were sent a letter outlining the aims and format of the study. A short time later each participant was contacted personally to see if they would be willing to take part in the study, and if so, to arrange an appointment. The data was collected using the semi-structured interview detailed above.

At the start of the interview it was explained that there was currently only a minimal clinical psychology service to psychiatry and that the intention of the study was to assess the priorities for input if a formal service were to be made available. In considering the role of clinical Psychology within Psychiatry the participants were asked to consider specifically the needs of the psychiatric service within that hospital. The participants were also reminded that this service was to be considered separately to any clinical psychology input to the Community Mental Health Teams or Community Addictions Team. The format of the interview was explained - quantitative and qualitative assessment of activities relating to the four categories of patients followed by a more general qualitative assessment. The interview procedure took between 30 - 45 minutes for each participant.

Results

The quantitative data obtained can be considered according to three criteria:

(i) The range of values expressed for each activity in each category.

(ii) The number of participants who perceived an activity as most or least useful.

(iii) The degree to which scores for an activity were generally high or generally low - the trend.

Two activities stood out when examined on all three criteria:

1. Neuropsychological assessment for patients within the category of organic disorders.

2. Therapy for individual patients within the category of affective disorders and sexual abuse.

These activities had the lowest range of values (20% and 40%), and were the activities rated as most useful by the greatest number of participants, and the ratings of usefulness given were all high.

(i) Range - Overall, a wide range of values were given for each activity within each category of patients. The exceptions to this were the two activities noted above. The next closest range was for consultancy regarding patients in the category of affective disorders and sexual abuse (50% - 100% - range 50%) and consultancy regarding the category of participants with organic disorders (30% - 80% - range 50%). For the majority of remaining activities a range of values between 70% - 90% was common. The most extreme range noted was with regard to group therapy for patients in the category of psychotic disorders. In this case, values given ranged from 0% - 100%, range 100%. (See Table 1)

(ii) Most/Least useful - The activities rated as most or least useful by the participants within each category of patients were identified. As some activities were given equal ratings, up to three activities could be identified as most or least useful by each participant in each category. If four or more activities received the same rating it was considered that no activity had been specified as most/least useful. (See Table 2)

Within the category of affective disorders and sexual abuse, therapy for individual patients was specified as most useful (7 participants) while activities identified as least useful were neuropsychological assessment (6 participants) and monitoring of psychological aspects of medicine/health (5 participants).

Within the category of psychotic disorders no activity was specified as most useful by more than 3 participants while activities specified as least useful were monitoring of recurrent symptoms (6 participants) and group therapy (5 participants).

Within the category of personality disorders, assessment of individual patients was identified as the most useful activity (5 participants) while activities identified as least useful were neuropsychological assessment and group therapy (both 6 participants), monitoring of recurrent symptoms and monitoring of psychological aspects of medicine/health (both 5 participants).

Within the category of organic disorders neuropsychological assessment was clearly identified as the most useful activity (10 participants) with consultancy identified as most useful by 5 participants. Group therapy was identified as the least useful activity (7 participants).

(iii) General trends within the data - Finally, trends within the data were assessed to see if values given for activities were generally high (60% and above) or generally low (40% and below), as rated by 10 or more of the participants (See Table 3). Two activities were highly rated by all participants, and were those previously identified: Neuropsychological assessment within the category of organic disorders and Therapy for individual patients within the category of affective disorders and sexual abuse.

Consultancy was generally highly rated across all four categories.

Assessment of individual patients was highly rated for all categories except that of psychotic disorders and Teaching was highly rated for all categories except that of organic disorders.

Supervision of psychiatric staff was generally highly rated within the categories of affective disorders/sexual abuse and personality disorders.

High ratings were given to: Training within the category of affective disorders and sexual abuse, Couple/Family therapy within the category of psychotic disorders, and supervision of psychiatric trainees within the category of personality disorders.

The picture was less clear with regard to activities given generally low ratings. Group therapy was given low ratings with regards to the categories of psychotic disorders and organic disorders, while monitoring of psychological aspects of medicine/health was given low ratings with regards to the categories of affective disorders/sexual abuse and personality disorders. In addition neuropsychological assessment was given low ratings with regards to the category of affective disorders and sexual abuse.

Discussion

From the data obtained it is clear there is a wide range of views on the role of clinical psychology within the psychiatric service at this hospital. Two activities where a role for clinical psychology input was identified were: (i) Therapy for individual patients within the category of affective disorders and sexual abuse and (ii) Neuropsychological assessment within the category of organic disorders. All participants interviewed identified these as useful activities. Other than this clear

priorities for clinical psychology input were not immediately obvious. However, the qualitative data elicited does help to clarify that situation.

One encouraging feature of this data is that all the participants interviewed stated that they would welcome psychological input to the psychiatric service. Many of those questioned said they felt it was important to encourage multi-disciplinary working and that Psychology's skills and training were vital to this - particularly with regard to providing models of care other than a strictly medical model. Several participants reported that they felt access to psychological assessment would help to focus treatment appropriately and that access to psychological therapies would enhance patient care. However, as can be seen, perception of the form this psychological input should take varied considerably.

Analysis of the qualitative data demonstrated that, while an activity might receive a low rating of usefulness for input from psychology, it did not necessarily mean that the activity was perceived as not valuable. Instead, this rating often seemed to reflect the fact that psychological input was viewed as a scarce resource and that the activity in question was not seen as the most effective use of that resource. One example of this was with regard to the activities of monitoring of recurrent symptoms or monitoring of psychological aspects of medicine or health related issues across all categories of patients. A substantial proportion of participants reported that while psychologists might be able to contribute to these activities, they were already well covered by the psychiatric staff and so were not a priority for psychological input. However, other participants did state that they felt these activities were the exclusive responsibility of medical personnel.

With regard to the category of affective disorders and sexual abuse certain themes did emerge. One was that this was an area where clinical psychology input could be particularly effective. Several participants stated a preference for a service delivery of training and supervision of staff with regards to activities such as anxiety management and some cognitive therapy, with direct psychological therapy for patients with particularly severe or complex problems. In particular, it was felt that patients with post-traumatic stress disorder, chronic obsessive-compulsive disorders, and those who had experienced sexual abuse would benefit most from psychological therapies. It was also suggested that for these patients, psychological treatment would actually be more appropriate than being managed within a medical model.

Perception of psychological input with regard to the category of psychotic disorders was less clear. A number of participants stated that they were uncertain what the role of a clinical psychologist within psychosis could be and that they would want information on the type of services that could be provided. One participant suggested that input would be best provided through increased services to the Community Mental Health Teams. Some areas of intervention were identified as potentially useful, such as Cognitive-Behaviour Therapy for psychosis, and psychological input through family therapy particularly regarding High Expressed Emotion within families. However, a number of participants stated that they felt a good service was already provided for patients within this category and also that intensive talking therapies or group therapies could actually be harmful. Alternatively though, at least three participants did identify psychotic disorders as an area where psychological input was likely to increase in the future.

The question of psychological input for patients within the category of personality disorders probably produced the widest range of views and may have reflected several participants uncertainties about what form psychological input could even take. These opinions ranged from a view that psychological input could be of only limited effectiveness to the view that all referrals should go to psychology as it was inappropriate to manage these patients within a medical model. In addition, at least two participants stated that they felt group therapies were positively harmful for these patients. However, several participants stated that they felt it would be important to have psychological input as these patients could be difficult to manage and a detailed psychological assessment combined with a consultancy role would be very helpful to this process. Areas of particular concern surrounded all staff involved giving consistent messages within clear, agreed guidelines and limits, and that psychology input would be helpful in establishing these boundaries.

Within the category of organic disorders, psychological input was clearly prioritised with regards to neuropsychological assessment. The majority of participants expressed a view that this was particularly important to allow identification of deficits and thus to focus treatment and management of patients. However, several participants also stated that they felt a wider psychological assessment was also important as these patients were often treated very medically and aspects of psychological functioning could be neglected. A common theme was that psychological intervention was of limited utility for the patient directly involved but that psychological input could be usefully targeted at families and carers. It was

emphasised that psychological input to these patients should be as part of a whole-team approach.

Overall, most participants reported that the majority of possible activities a psychologist might be involved in had been addressed although several participants identified services for patients with eating disorders as a possible area for psychological input. It was also suggested that it would be valuable to have psychological input within the day-hospital and in-patient service for selected patients as well as for outpatients.

Implications

Given the wide range of ratings on almost all activities the priorities for psychological input to the psychiatric service are not immediately obvious. Notable exceptions to this are:

(i) Neuropsychological assessment within the category of organic disorders.
(ii) Therapy for individual patients within the category of affective disorders and sexual abuse, with priority for direct intervention regarding patients with post-traumatic stress disorder, chronic obsessive-compulsive disorders, and those who have experienced sexual abuse.

However, it should be noted that all participants interviewed stated that psychological input was wanted and was perceived as valuable.

When establishing a pattern of service delivery it would seem helpful to target the two activities noted above. Development of a needs-led service would be further guided by the more general trends identified, such as the generally high ratings given to Consultancy across all four categories. While there may not currently be clear priorities to fulfil, the identification of needs is likely to become clearer as the service is implemented. Indeed it may be helpful to regard this process as an important aspect of service development.

One activity, which should be given priority, is provision of information on services the clinical psychology service could provide within psychiatry. The current pattern of responding seems to reflect uncertainty over what the role of the psychologist could be, particularly regarding work within the categories of psychotic disorders and personality disorders. It is possible that this provision of information may help to establish clearer priorities for psychological input.

The results currently obtained do have implications for auditing of this service when established. Given that there is not currently a clearly identified need to fulfil it is then difficult to assess how well service needs are being met. As a psychology service is implemented it is likely that there may be considerable initial shifting of views and priorities and an audit process would need to allow for that. The data obtained provide a baseline measure and further auditing would need to be from the perspective of a developing service. It would be particularly helpful to assess if more consistent priorities do develop and to investigate the reasons for this shift.

Table 1. Range of Values According to Activity and Category of Patient

Activity	Affective Disorders and Sexual Abuse			Psychotic Disorders			Personality Disorders			Organic Disorders		
	Min.	**Max.**	**Range**	**Min.**	**Max.**	**Range**	**Min.**	**Max.**	**Range**	**Min.**	**Max.**	**Range**
1. Assessment of Individual Patients	20%	100%	80	15%	90%	75	10%	95%	85	10%	90%	80
2. Neuropsychological Assessment	0%	80%	80	0%	80%	80	0%	70%	70	70%	90%	20
3. Therapy for Individual Patients	60%	100%	40	20%	80%	60	5%	100%	95	10%	85%	75
4. Group Therapy	0%	90%	90	0%	100%	100	0%	90%	90	0%	80%	80
5. Monitoring of Recurrent Symptoms	5%	80%	75	0%	85%	85	0%	80%	80	5%	80%	75

Activity	Affective Disorders and Sexual Abuse			Psychotic Disorders			Personality Disorders			Organic Disorders		
	Min.	**Max.**	**Range**	**Min.**	**Max.**	**Range**	**Min.**	**Max.**	**Range**	**Min.**	**Max.**	**Range**
6. Couple/Family Therapy	5%	95%	90	15%	80%	65	10%	90%	80	10%	90%	80
7. Monitoring of Psychological Aspects of Medicine/Health Related Issues	0%	90%	90	0%	80%	80	0%	90%	90	0%	90%	90
8. Supervision of Psychiatric Trainees	20%	100%	80	5%	80%	75	0%	90%	90	10%	80%	70
9. Supervision of other Psychiatric Staff	20%	100%	80	10%	80%	70	0%	80%	80	5%	90%	85
10. Teaching	30%	100%	70	5%	80%	75	5%	80%	75	20%	80%	60
11. Training	40%	100%	60	5%	80%	75	10%	80%	70	20%	80%	60
12. Consultancy/ Case Discussion	50%	100%	50	15%	80%	65	10%	97.5%	87.5	30%	80%	50

Table 2. Activities Rated as Most and Least Useful

	Affective Disorders and Sexual Abuse		Psychotic Disorders		Personality Disorders		Organic Disorders	
Activity	**Most use**	**Least use**	**Most use**	**Least use**	**Most use**	**Least use**	**Most use**	**Least use**
1. Assessment of Individual Patients	2	2	1	1	5	2	3	1
2. Neuropsychological Assessment	0	6	2	1	0	6	10	0
3. Therapy for Individual Patients	7	0	3	2	3	1	0	3
4. Group Therapy	1	2	2	5	0	6	0	7
5. Monitoring of Recurrent Symptoms	1	4	2	6	0	5	0	2
6. Couple/Family Therapy	2	1	2	0	3	2	2	0
7. Monitoring of Psychological Aspects of Medicine/Health Related Issues	0	5	2	4	1	5	0	4
8. Supervision of Psychiatric Trainees	1	2	1	1	1	1	0	1

Activity	Affective Disorders and Sexual Abuse		Psychotic Disorders		Personality Disorders		Organic Disorders	
	Most use	**Least use**	**Most use**	**Least use**	**Most use**	**Least use**	**Most use**	**Least use**
9. Supervision of other Psychiatric Staff	1	1	1	0	1	1	0	0
10. Teaching	2	0	2	0	2	0	0	2
11. Training	2	0	2	0	2	0	0	2
12. Consultancy	1	0	3	0	2	0	5	0
>3 Activities Specified	4	0	1	4	1	1	2	2

Table 3. General Trends of values within the data

	Activity	Category of Patients			
		Affective Disorders and Sexual Abuse	**Psychotic Disorders**	**Personality Disorders**	**Organic Disorders**
1.	Assessment of Individual Patients	High	Mixed	High	High
2.	Neuropsychological Assessment	Low	Mixed	Mixed	High
3.	Therapy for Individual Patients	High	Mixed	Mixed	Mixed
4.	Group Therapy	Mixed	Low	Mixed	Low
5.	Monitoring of Recurrent Symptoms	Mixed	Mixed	Mixed	Mixed
6.	Couple/ Family Therapy	Mixed	High	Mixed	Mixed
7.	Monitoring of Psychological Aspects of Medicine/Health Related Issues	Low	Mixed	Low	Mixed

		Category of Patients			
	Activity	**Affective Disorders and Sexual Abuse**	**Psychotic Disorders**	**Personality Disorders**	**Organic Disorders**
8.	Supervision of Psychiatric Trainees - SHOs and GPs in Training	Mixed	Mixed	High	Mixed
9.	Supervision of other Psychiatric Staff	High	Mixed	High	Mixed
10.	Teaching	High	High	High	Mixed
11.	Training	High	Mixed	Mixed	Mixed
12.	Consultancy/ Case Discussion	High	High	High	High

References

1. Conning AM. The role of the psychologist in psychiatric rehabilitation. International Review of Psychiatry, 1991, 3, 83 - 93

2. Feinmann C & Harrison S. Liaison Psychiatry and Psychology in Dentistry. Journal of Psychosomatic Research, 1997, 43, 467-476

3. Albeniz A & Holmes J. Psychotherapy Integration: Its implications for Psychiatry. British Journal of Psychiatry, 1996, 169, 563-570

4. Lavender A & Watts FN. Rehabilitation: Intervention. In: Lindsay SJE & Powell GE (Eds). The Handbook of Clinical Adult Psychology(2nd Ed). London. Routledge, 1994

5. Edelmann RJ. An introduction to health psychology. In: Lindsay SJE & Powell GE (Eds). The Handbook of Clinical Adult Psychology(2nd Ed). London. Routledge, 1994

6. Parry G. Care for the future. The Psychologist. October 1989 436 - 438

7. Parry G. Improving psychotherapy services: Applications of research, audit and evaluation. British Journal of Clinical Psychology, 1992, 31, 3-19.

8. Milne D. Evaluation in Clinical Psychology: Outcome evaluation of a routine Clinical Psychology Service. In Milne D. (Ed.). Evaluating Mental Health Practice: Methods and Applications. London. Croom Helm. 1987.

5. CLINICAL CASE RESEARCH STUDY (ABSTRACT)

Establishing New Activities In An Individual With Autism

Who Showed Marked Withdrawal

Kerry Teer

Department of Psychological Medicine, Faculty of Medicine, University of Glasgow

Written in accordance with guidelines for submission to

Research in Developmental Disabilities

Abstract

Individuals with autistic disorders may experience difficulties coping with social environments such as day care services. This paper describes an intervention with an individual who was showing high levels of withdrawal within his day service. Sensory stimuli were provided in three conditions: (i) modelling, (ii) prompting, (iii) observation. There was limited success in increasing engagement. This seemed to be particularly related to failure to alter well established environmental cues. Difficulties and implications of the study are discussed.

Appendix 1: Major Research Project Literature Review

Psychological Medicine is a journal primarily for the publication of original research in clinical psychiatry and the basic sciences related to it. These comprise not only the several fields of biological enquiry traditionally associated with medicine but also the various psychological and social sciences, the relevance of which to medicine has become increasingly apparent. Review articles and book reviews are also published. Contributions must be in English.

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Appendix 2: Major Research Project Proposal

HELP-SEEKING

In the past month:

1. Were you in contact with any of the following?
2. Did you discuss any difficulties you have been experiencing?

		1. How often were you in contact with:	2. Did you discuss any difficulties	
			Yes (How often)	No
1	Spouse/Partner			
2	Close Friend			
3	Family Member			
4	GP			
5	Telephone Support Service e.g. Samaritans			
6	Voluntary Support Group e.g. Glasgow Association for Mental Health, Alcoholics Anonymous etc.			
7	Mental Health Professional e.g. CPN, Psychologist			
8	Psychiatrist			

Risk Factor Assessment Measure

1. Age	

2. Sex	
Male	
Female	

3. Employment status	
Unemployed	
Temporary employment	
In employment but job uncertain	
Paid employment	
Long term sick leave	

4. Emotional Difficulties	
Are you currently experiencing difficulties regarding:	
Depression	
Anxiety	
Bereavement	
Other (specify)	

5. Psychiatric Disorder		
	Ever diagnosed as suffering	Currently receiving treatment for
Schizophrenia		
Bi-polar disorder		
Other disorder (specify)		

6. Physical Illness	
Are you currently experiencing any physical illness which you feel seriously affects your life (specify)	

7. Substance misuse		
	Typical weekly use	Use in last week
Alcohol		
Drugs		

8. Relationship difficulties	
Are you currently experiencing difficulties in any close personal relationships	
Spouse/partner	
Close friend	
Other (specify)	

9. Family difficulties	
Are you currently experiencing difficulties in relationships within your close family	
Parents	
Brother/Sister	
Children	
Other (specify)	

10. Experience of suicide		
	Attempted suicide	Committed suicide
Has anyone within your family		
Have any of your friends		

Greater Glasgow Primary Care NHS Trust

Information Sheet

Social Support and Help Seeking in Serious Self-Harm versus Depression in Young Adults

We would like to invite you to participate in a research study looking at sources of support and help for people who have experienced depression, or who have felt so distressed that they have harmed themselves. We hope that this will help us to understand what things may be difficult and what sort of support would be helpful.

Your participation would involve an interview with a researcher, which would last about an hour and a half. During the interview you will be asked to complete some questionnaires about how you are feeling currently, how different situations may make you feel, and the sort of support which you feel is available from family, friends or professional staff. The interview will normally be completed in one session but can be completed over two sessions if you prefer.

All your answers are confidential and will only be seen by the staff involved in the study. You will not be identified by name during the study. The study may be written up for publication in a medical or psychological journal but your identity will be kept anonymous

Your GP will be informed that you are taking part in the study but we will not be asking them for any information about you.

You are free to decline participation in this study. If you do take part, you may withdraw from the study at any time if you so wish. Neither option will affect your treatment in any way.

If you are willing, your name will be given to a researcher who will contact you in the next 2-3 days to answer any questions you may have and to ask your consent to be involved in the study.

Contact:
Dr. Kerry Teer
University Department of Psychological Medicine
Academic Centre
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0HX
0141 958 1608

Greater Glasgow Primary Care NHS Trust

Consent Form

Social Support and Help Seeking
in Serious Self-Harm versus Depression in Young Adults

By signing this form you give consent to your participation in the project whose title is at the top of this page. You should have been given a complete explanation of the project to your satisfaction and have been given the opportunity to ask questions.

You should have been given a copy of the patient information sheet approved by the Primary Care Trust Ethics Committee to read and to keep.

Even though you have agreed to take part in the research procedures you may withdraw this consent at any time without the need to explain why and without any prejudice to your care

I _____ (Print)

of _____

Give my consent to the research procedures above, the nature, purpose and possible consequences of which have been described to me

by _____

Patient's signature _____ Date _____

Researcher's signature _____

Appendix 3: Major Research Project Paper

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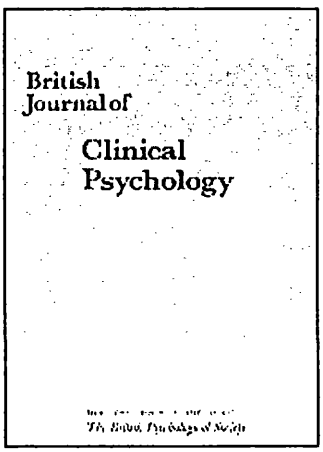

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LE1 7DR
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The Editorial Board will reject papers which evidence discriminatory, unethical or unprofessional practices.

The Journal operates a policy of blind peer review. Papers will normally be scrutinized and commented on by at least two referees as well as by the Editor or an Associate Editor. The referees will not be made aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to a removable front page and the text should be free of all such clues as identifiable self-citations ("In our earlier work..."). The paper's title should be repeated on the first page of the text.

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Contributions should be prepared in accordance with The British Psychological Society's *Style Guide* available online, or in printed format from mail@bps.org.uk.

Contributions should be as concise as clarity permits, and illustrations kept as few as possible. Papers should not normally exceed 5000 words. A structured abstract of up to 250 words should be provided. The title should indicate exactly but as briefly as possible the subject of the article, bearing in mind its use in abstracting and indexing schemes.

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Results:
State the main results of the study. Numerical data may be included but should be kept to a minimum.
Conclusions:
State the conclusions that can be drawn from the data provided, and their clinical implications (if appropriate).

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State the primary objectives of the review.
Methods:
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Results:

State the main results of the review.
Conclusions:
State the conclusions that can be drawn from the review, and their clinical implications if appropriate.

Authors please note: Revisions without a structured abstract will not be considered for publication.

1. Contributions should be typed in double spacing with wide margins and on only one side of each sheet. Sheets should be numbered. The top copy and three good copies should be submitted and a copy retained by the author.

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   Particular care should be taken to ensure that references are accurate and complete.

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Appendix 4: Major Research Project Paper

Normative Data for the Test of Self-Conscious Affect (TOSCA)

College Students' Subscale Means and Standard Deviations

Sample Description	Sex	Shame	Guilt	Extern.	Detach.	A-Pride	B-Pride
GMU90F:							
College students from a large public university receiving credit for a psychology course requirement	Female (n=147)	42.04 (8.68)	59.10 (6.14)	37.22 (8.22)	30.86 (5.77)	21.32 (2.39)	21.63 (2.63)
	Male (n=51)	40.65 (7.79)	56.35 (6.25)	39.29 (7.25)	32.70 (5.65)	20.35 (2.63)	21.06 (2.60)
GMU91F:							
College students from a large public university receiving credit for a psychology course requirement	Female (n=134)	45.34 (7.83)	59.32 (5.96)	37.37 (5.94)	30.48 (4.78)	20.25 (2.58)	20.47 (2.50)
	Male (n=48)	39.25 (6.74)	55.00 (6.18)	38.50 (6.96)	32.85 (4.72)	19.42 (2.75)	20.62 (2.18)
DISS92:							
College students from a large public university receiving credit for a psychology course requirement	Female (n=188)	44.00 (7.97)	59.60 (6.53)	36.46 (5.76)	29.59 (5.09)	20.06 (2.72)	20.44 (2.45)
	Male (n=76)	39.90 (8.36)	55.24 (6.76)	38.49 (6.79)	31.51 (5.14)	19.84 (2.81)	20.41 (2.74)
GMU92F:							
College students from a large public university receiving credit for a psychology course requirement	Female (n=181)	46.16 (7.67)	60.37 (5.24)	37.98 (6.15)	31.11 (5.32)	20.26 (2.78)	20.87 (2.60)
	Male (n=73)	39.82 (8.72)	56.97 (6.13)	39.34 (8.04)	32.90 (4.96)	19.55 (2.50)	20.51 (2.46)

Note: Standard deviations appear in parenthesis below means. Shame, Guilt, and Externalization scales are derived from 15 items each, Detachment from 10 items, and Alpha Pride and Beta Pride from 5 items each. Items are rated on a 5-point scale (1-5).

Appendix 5: Small Scale Service Evaluation Project

INSTRUCTION TO AUTHORS

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Original articles should be submitted to:

Ms Mary Edwards
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The title page should give the following information:

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- telephone and fax contact numbers.

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This should consist of not more than 150 words summarizing the contents of the article.

Text
Headings should be appropriate to the nature of the paper, the use of headings enhances readability.

Do not use 'he', 'his' etc. where the sex of the person is unknown: say 'the patient' etc. Avoid inelegant alternatives such as 'he/she'.

References
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Small J O. Management alternatives. Journal of Health Services Research and Policy 1995; 1(1): 22–25

References to books should be set out as follows:
McKinney P, Conn B. Management Ethics. Edinburgh: Churchill Livingstone, 1995

Statistics
Numerical data should be analysed by appropriate statistical methods.

The use of standard deviation and standard error should be clearly distinguished. Use of '±' symbol should be avoided; these statistics should be presented in parentheses after the mean value.

Tables
These should be double spaced on separate sheets and contain only horizontal rules. A short descriptive title should appear above each table and any footnotes suitably identified. Ensure that each table is cited in the text.

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Appendix 6: Small Scale Service Evaluation Project

Respondent Orientation Sheet

Response Scale

0% 100%

not a useful activity most useful activity

Categories of Patient

1. Affective Disorders and Sexual Abuse
e.g. Anxiety, Depression, Phobias, Obsessive-Compulsive disorder, Post-Traumatic Stress Disorder, Sexual Abuse, Adjustment disorders.

2. Psychotic Disorders
e.g. Schizophrenia, Schizoaffective disorder, Bi-polar disorder, Delusional disorders, Non-organic psychosis

3. Personality Disorders
e.g. Paranoid personality disorder, schizotypal personality disorder, borderline personality disorder.

4. Organic Disorders
e.g. Dementia - due to Alzheimer's, Huntington's, Parkinson's, HIV, CJD

Clinical Activities

1.	Assessment of individual patients	
2.	Neuropsychological assessment	
3.	Therapy for individual patients	
4.	Group Therapy	
5.	Monitoring of recurrent symptoms	
6.	Couple/Family Therapy	
7.	Monitoring of psychological aspects of medicine/health related issues	
8.	Supervision of psychiatric trainees - SHOs and GPs in training	
9.	Supervision of other psychiatric staff	
10.	Teaching	
11.	Training	
12.	Consultancy/case discussion	

Semi-structured interview

1. Affective Disorders and Sexual Abuse
e.g. Anxiety, Depression, Phobias, Obsessive-Compulsive disorder, Post-Traumatic Stress Disorder, Sexual Abuse, Adjustment disorders.

1.	Assessment of individual patients	
2.	Neuropsychological assessment	
3.	Therapy for individual patients	
4.	Group Therapy	
5.	Monitoring of recurrent symptoms	
6.	Couple/Family Therapy	
7.	Monitoring of psychological aspects of medicine/health related issues	
8.	Supervision of psychiatric trainees - SHOs and GPs in training	
9.	Supervision of other psychiatric staff	
10.	Teaching	
11.	Training	
12.	Consultancy/case discussion	

Activity identified as most useful:
Can you tell me in what way you feel this would be a useful activity ?

Activity identified as least useful:
Can you tell me in what way you feel this would not be a useful activity ?

Have you any general comments about the contribution clinical psychology can make to the psychiatric service with regard to this category of patients?

Any other comments

2. Psychotic Disorders
e.g. Schizophrenia, Schizoaffective disorder, Bi-polar disorder, Delusional disorders, Non-organic psychosis

1.	Assessment of individual patients	
2.	Neuropsychological assessment	
3.	Therapy for individual patients	
4.	Group Therapy	
5.	Monitoring of recurrent symptoms	
6.	Couple/Family Therapy	
7.	Monitoring of psychological aspects of medicine/health related issues	
8.	Supervision of psychiatric trainees - SHOs and GPs in training	
9.	Supervision of other psychiatric staff	
10.	Teaching	
11.	Training	
12.	Consultancy/case discussion	

Activity identified as most useful:
Can you tell me in what way you feel this would be a useful activity ?

Activity identified as least useful:
Can you tell me in what way you feel this would not be a useful activity ?

Have you any general comments about the contribution clinical psychology can make to the psychiatric service with regard to this category of patients?

Any other comments

3. Personality Disorders
e.g. Paranoid personality disorder, schizotypal personality disorder, borderline personality disorder.

1.	Assessment of individual patients	
2.	Neuropsychological assessment	
3.	Therapy for individual patients	
4.	Group Therapy	
5.	Monitoring of recurrent symptoms	
6.	Couple/Family Therapy	
7.	Monitoring of psychological aspects of medicine/health related issues	
8.	Supervision of psychiatric trainees - SHOs and GPs in training	
9.	Supervision of other psychiatric staff	
10.	Teaching	
11.	Training	
12.	Consultancy/case discussion	

Activity identified as most useful:
Can you tell me in what way you feel this would be a useful activity ?

Activity identified as least useful:
Can you tell me in what way you feel this would not be a useful activity ?

Have you any general comments about the contribution clinical psychology can make to the psychiatric service with regard to this category of patients?

Any other comments

4. Organic Disorders
e.g. Dementia - due to Alzheimer's, Huntington's, Parkinson's, HIV, CJD

1.	Assessment of individual patients	
2.	Neuropsychological assessment	
3.	Therapy for individual patients	
4.	Group Therapy	
5.	Monitoring of recurrent symptoms	
6.	Couple/Family Therapy	
7.	Monitoring of psychological aspects of medicine/health related issues	
8.	Supervision of psychiatric trainees - SHOs and GPs in training	
9.	Supervision of other psychiatric staff	
10.	Teaching	
11.	Training	
12.	Consultancy/case discussion	

Activity identified as most useful:
Can you tell me in what way you feel this would be a useful activity ?

Activity identified as least useful:
Can you tell me in what way you feel this would not be a useful activity ?

Have you any general comments about the contribution clinical psychology can make to the psychiatric service with regard to this category of patients?

Any other comments

In General:

Are there any activities you feel would be helpful that have not been mentioned ?

Overall, how do you view psychological input to the psychiatric service ?

Any other comments